

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #26, per Phy. State of Maryland / Department of Health and Mental Hygiene  
6/30/99, Carroll County, wjl

Certificate of Death

Reg. No.

99 22001

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Mary Brown</b>				2. Date of Death Month Day Year <b>June 25, 1999</b>		3. Time of Death <b>17:45</b>		
	4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard County</b>		
Funeral Director	5. Social Security Number <b>219-74-3807</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 4, 1910</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Dayton</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>13825 Howard Road</b>		10f. Zip Code <b>21036</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>		17. Father's Name (First, Middle, Last) <b>Clay Dorsey Hobbs</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Eva Carroll</b>	
19e. Informant's Name/Relationship (Type, Print) <b>Mr. Clyde H. Brown, Sr. (Husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13825 Howard Road Dayton, MD 21036</b>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Marks Episcopal Cem.</b>		Date <b>6/29/99</b>		20c. Location - City or Town, State <b>Highland, MD</b>			
21. Signature of Funeral Service Licensee <b>Brian D. Haight</b>		22. Name and Address of Facility <b>HAIGHT FUNERAL HOME &amp; CHAPEL, P.A. (Box 195) Sykesville, MD 21784 (410)-795-1400</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Acute Myocardial Infarct</b> Due to (or as a consequence of): b. <b>Arteriosclerotic Heart Disease</b> Due to (or as a consequence of): c. <b>Insulin Dependant Diabetes Mellitus</b> Due to (or as a consequence of): d. <b>Peripheral Vascular Disease</b>		Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>N/A</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. Location (Street and Number or Rural Route Number, City or Town, State)							
29b. Signature and title of certifier <b>Daniel T. Anderson MD</b>		29c. License number <b>D 3592</b>		29d. Date signed (Month, Day, Year) <b>June 28, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Daniel Anderson, M.D. 2901 Sandy Spring Rd, Olney, MD 20832</b>									
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature <b>Beverly S. Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22002

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy May Bulgin

2. Date of Death

Month Day Year  
6 17 99

3. Time of Death

1730

4a. Facility Name (If not Institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

202-18-0200

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 21, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

DE

10b. County

Sussex

10c. City, Town or Location

Millsboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 3 Box 203 C

10f. Zip Code

19966

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dispatcher

16b. Kind of Business/Industry

Gas Company

17. Father's Name (First, Middle, Last)

Virgil Fooks

18. Mother's Name (First, Middle, Maiden Surname)

Olwyn (maiden unknown) Fooks

19a. Informant's Name/Relationship (Type, Print)

Richard A. Bulgin/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt 3 Box 203 C Millsboro, De 19966

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cambridge Crematory

Date

6-18-99

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

*William M. Smith*

22. Name and Address of Facility

Short Funeral Home, Inc.  
13 E. Grove St. Delmar, DE 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BLADDER CA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. BLADDER CA

Due to (or as a consequence of):

10 MON.

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD, SIP LABS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*D. Chadnicki*

29c. License number

020912

29d. Date signed (Month, Day, Year)

6-18-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chadnicki

31. Date filed (Month, Day, Year)

JUN 21 1999

32. Registrar's Signature

*Gene B. Sparks*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

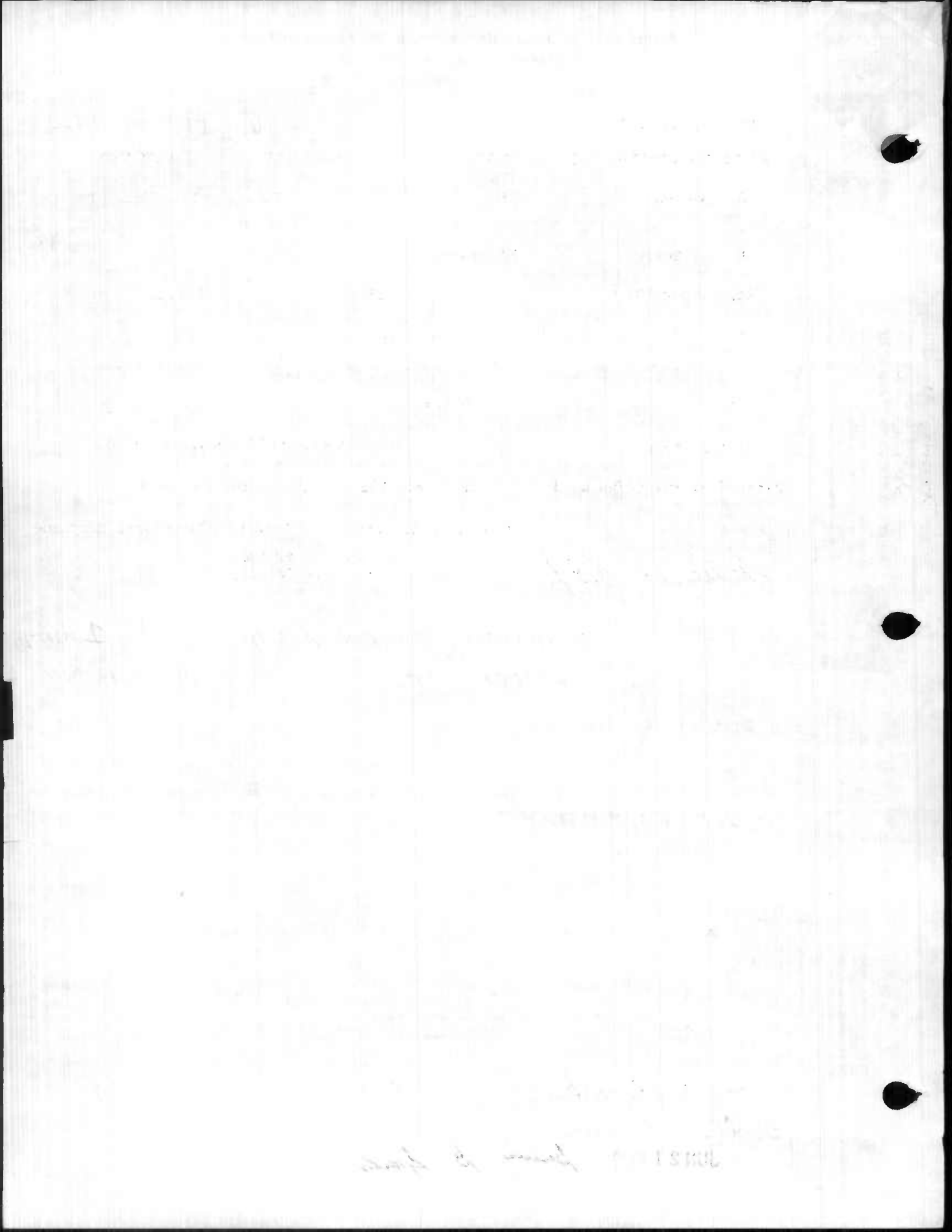
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22003

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frances L Callahan</b>				2. Date of Death Month Day Year <b>June 23 1999</b>		3. Time of Death <b>7:32 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>494-12-3865</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 20, 1912</b>		
	9. Birthplace (State or Foreign Country) <b>NEBRASKA</b>		10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>WHEATON</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>11601 CHANNING DR.</b>		10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>		16b. Kind of Business/Industry <b>CLERICAL</b>					
17. Father's Name (First, Middle, Last) <b>FREDRICK SCHLEIGER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>KATHERINE SCHIEDEMANN</b>							
19a. Informant's Name/Relationship (Type, Print) <b>KATHERINE WINSLOW/NIECE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5831 NAHANE EAST N.E., TACOMA, WA. 98422</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		20c. Location - City or Town, State <b>6/26/99 RIVERDALE, MD.</b>					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Ruptured Aortic Aneurysm / cardiac arr</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> D.O.A. Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D0040948</b>		29d. Date signed (Month, Day, Year) <b>6/25/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Julie Fox M.D. 10313 Georgia Ave Ste 209 Silver Spring, Md 20902</b>									
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22004

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT BARNES CASADY					2. Date of Death Month Day Year JUNE 22, 1999			3. Time of Death 9:05 P.M.	
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL					4b. City, Town, or Location of Death SILVER SPRING			4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 548-24-8641		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 29, 1917		9. Birthplace (State or Foreign Country) CALIFORNIA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1320 CHILTON DRIVE				10f. Zip Code 20904		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ANIMAL BEHAVIOR PHYSIOLOGIST				16b. Kind of Business/Industry U.S.D.A.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) PHILIP MURRAY CASADY					18. Mother's Name (First, Middle, Maiden Surname) NINA BARNES MILLER				
	19a. Informant's Name/Relationship (Type, Print) STELLA D. CASADY/SPOUSE					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1320 CHILTON DRIVE SILVER SPRING, MARYLAND 20904				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FT. LINCOLN CREMATORY		Date 6/26/99		20c. Location - City or Town, State BRENTWOOD, MARYLAND			
	21. Signature of Funeral Service Licensee Alamy Daniels					22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death TWO YEARS TWO YEARS+ FIVE YEARS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA RENAL INSUFFICIENCY								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier B. F. Reagan MD				29c. License number D 45121		29d. Date signed (Month, Day, Year) JUNE 23, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN F. REAGAN, M.D. 1500 FOREST GLEN AVENUE SILVER SPRING, MARYLAND 20905									
State Registrar	31. Date filed (Month, Day, Year) JUN 28 1999		32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22005

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lena Childs				2. Date of Death Month Day Year June 30, 1999				3. Time of Death 3:00 AM			
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney, MD				4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 579-16-6299		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 102 Yrs.		8. Date of Birth (Month, Day, Year) June 18, 1897		9. Birthplace (State or Foreign Country) Rockville, MD			
	Usual Residence of Decedent				10a. State D.C.				10b. County N/A		10c. City, Town or Location Washington	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 32 Quincy Place, N.W.				10f. Zip Code 20001		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician				16b. Kind of Business/Industry Cosmetology			
	17. Father's Name (First, Middle, Last) Unavailable				18. Mother's Name (First, Middle, Maiden Surname) Mary Dyson							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Dr. Janet Stiles/Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6562 Mitchell Lane, Mableton, Georgia 30126							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc.				20c. Location - City or Town, State Beltsville, MD		20d. Date 7/2/99	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Lynne McGuire</i>				22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, D.C. 20012							
	23a. Path. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Hypercarbic and Hypoxemic Respiratory Failure with Pneumonia</i> Due to (or as a consequence of): b. <i>Pneumonia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>							
	29c. License number D51108				29d. Date signed (Month, Day, Year) 6/30/99							
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type - Print) 1811 Prince Philip Drive Suite 327 Olney MD 20852											
	31. Date filed (Month, Day, Year) JUL 02 1999				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22006

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUBIN I. COHEN

2. Date of Death

06.26.1999

Year

3. Time of Death

6:45 PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

578.10.0435

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05.29.1914

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3813 JEFFREY STREET

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

GROCER

16b. Kind of Business/Industry

RETAIL MERCHANT

17. Father's Name (First, Middle, Last)

DAVID COHEN

18. Mother's Name (First, Middle, Maiden Surname)

RACHEL LEAH SENDLIN

19a. Informant's Name/Relationship (Type, Print)

PHILLIP COHEN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12401 LISBOROUGH RD, MITCHELLVILLE, MD 20720

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

6.29.99

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I - Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Congestive heart failure  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Endstage cardiomyopathy  
Due to (or as a consequence of):c. Coronary artery disease  
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. L. Bahaduri

10301 Georgia Ave #304 Silver Spring, MD 20902

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22007

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mario Concha

2. Date of Death

June 29, 1999

3. Time of Death

6:50 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

215-92-5194

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 24, 1924

9. Birthplace (State or Foreign Country)

Chile

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

405 Palmspring Drive

10f. Zip Code

20878

10g. Citizen of What Country?

Chile

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:  
Chilean14. Race - American Indian,  
Black, White, etc.Specify:  
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Guillermo Concha

18. Mother's Name (First, Middle, Maiden Sumame)

Julia Martinez

19a. Informant's Name/Relationship (Type, Print)

Leslie Concha (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13637 Winterspoon Lane Germantown, Maryland 20874

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

7/2/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Tracy A. Shiver

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Obstructive Pulmonary Disease

Years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumothorax with persistent air leak recent right

upper pulmonary lobectomy to correct air leak prior

mycobacterium ovarian intracellulare infection

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
investigation  
2 Accident 6 Could not be  
determined  
3 Suicide  
4 Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

1 Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Roy Fried, M.D.

29c. License number

D 34590

29d. Date signed (Month, Day, Year)

June 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roy Fried, M.D. Kaiser Office Holy Cross Hospital 1500 Forest Glen Road

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22008

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Grace Curry

2. Date of Death

Month Day Year  
June 27, 1999

3. Time of Death

5:15 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10225 Kensington Parkway, #406

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

192-01-5082

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 5, 1906

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10225 Kensington Parkway, #406

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Bailey Stephens

18. Mother's Name (First, Middle, Maiden Surname)

Laura Lynch

19a. Informant's Name/Relationship (Type, Print)

Lois C. Curry (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Grandview Cemetery

Date

July 1, 99

20c. Location - City or Town, State

Johnstown,  
Pennsylvania

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

b. Chronic Renal Failure

Due to (or as a consequence of):

c. Severe Anemia

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

&lt; 1 month

&gt; 6 months

&gt; 6 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive failure with transfusion (6-10-99)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Carolyn B. Hendricks MD

29c. License number

D 37236

29d. Date signed (Month, Day, Year)

June 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carolyn B. Hendricks, M. D., 5454 Wisconsin Avenue, #1345, Chevy Chase, MD 20815

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
card.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Addie Mary Cutsail</b>				2. Date of Death Month <b>06</b> Day <b>24</b> Year <b>99</b>		3. Time of Death <b>18:05</b>	
4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
5. Social Security Number <b>220-16-2164</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth Month <b>Mar</b> Day <b>11</b> Year <b>1910</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>7121 Gaither Road</b>				10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>	
17. Father's Name (First, Middle, Last) <b>Hayes Gue</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Burdette</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Helen Mercer (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7121 Gaither Road Sykesville, MD 21784</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springfield Cemetery</b>		Date <b>6/28/99</b>		20c. Location - City or Town, State <b>Sykesville, MD</b>	
21. Signature of Funeral Service Licensee <b>Brian A. Haight</b>				22. Name and Address of Facility <b>HAIGHT FUNERAL HOME &amp; CHAPEL, P.A. (Box 195) Sykesville, MD 21784 (410)-795-1400</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Sinus Node Arrest</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>5 minute</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>① spl INTERNAL fixation right hip for hip fracture ② mild dementia ③ noninsulin dependent diabetes mellitus ④ hypertension</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Thomas K. Galvin M.D.</b>				29c. License number <b>DB1660</b>		29d. Date signed (Month, Day, Year) <b>6/24/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1 THOMAS GALVIN MD 295 SIDNER AVE WESTMINSTER MD 21157</b>							
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature <b>B. Sparks</b>					

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22010

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jack Bertram Cox</b>				2. Date of Death Month <b>June</b> Day <b>25</b> Year <b>1999</b>		3. Time of Death <b>12:55 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>2869 Baltimore Boulevard, Room #1</b>				4b. City, Town, or Location of Death <b>Finksburg</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>227-70-7598</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>49</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 6, 1949</b>	
	9. Birthplace (State or Foreign Country) <b>Illinois</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> No				10e. Street and Number <b>500 Klee Mill Road</b>		10f. Zip Code <b>21784</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>				16b. Kind of Business/Industry <b>VA School System</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Stanley D. Cox</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marilyn Holst</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Stanley D. Cox Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>500 Klee Mill Road Sykesville, MD 21784</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremation, Inc.</b>		20c. Location - City or Town, State <b>6/30 Hampstead, MD</b>	
	21. Signature of Funeral Service Licensee <i>Jane B. Corey</i>				22. Name and Address of Facility <b>Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Intraoral Gunshot Wound</b>				Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>a. Due to (or as a consequence of):</b> <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown			
					24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>at scene</b>			
	27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year) <b>06-25-1999</b>		28b. Time of Injury <b>Found 11:59 A</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred <b>Subject shot self.</b>				28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>2869 Baltimore Blvd. Finksburg, Maryland.</b>			
	29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Dennis Chute</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>June 26, 1999</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>B. Sparks</i>				33. Date of Death (Month, Day, Year) <b>June 25, 1999</b>			
	34. Date of Death (Month, Day, Year) <b>June 25, 1999</b>				35. Date of Death (Month, Day, Year) <b>June 25, 1999</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Delores Coleman

2. Date of Death

June 30, 1999

3. Time of Death

9:15 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

90 Waverley Drive Apt. CC 104

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

097-40-4405

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 14, 1950

9. Birthplace (State or Foreign Country)

N.Y.

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

90 Waverley Drive Apt CC 104

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Management Restaurant

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Luther W. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Rillie

19a. Informant's Name/Relationship (Type, Print)

Doris Renee Stokes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19910 Sweetgum Circle Germantown, MD 20874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem. Gar. July 3, 99 Frederick, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gary L. Rollins

22. Name and Address of Facility

Gary L. Rollins Funeral Home 21701  
110 West South Street Frederick, MD

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Aids Due to (or as a consequence of):

14 y - 3

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hepatic Failure Due to (or as a consequence of):

6 mo

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregory Rausch

29c. License number

014525

29d. Date signed (Month, Day, Year)

July 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory Rausch 501 w 7th Street Frederick Md.

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22012

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Naomi Frances Coblentz

2. Date of Death

June 29, 1999

3. Time of Death

12:15 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

165-50-7578

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 31, 1905

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3715 Kayson St.

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Maurice Holter

18. Mother's Name (First, Middle, Maiden Surname)

Cora Main

19a. Informant's Name/Relationship (Type, Print)

Charles H. Coblentz (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3715 Kayson St., Wheaton, MD. 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Reformed Cemetery

Date

7/3

20c. Location - City or Town, State

Middletown, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home

31 E. Main St., Middletown, MD. 21769

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intra cerebral Hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rectal Bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D14876

29d. Date signed (Month, Day, Year)

6.29.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. S. G. Gupta

Randolph Road Rockville, MD 20853

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





99-3646-043

UNK 99-140

asp

JOSEPH CARTER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22013

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH R CARTER, SR.				2. Date of Death Month Day Year JUNE 28 1999		3. Time of Death 2:45 A
	4a. Facility Name (If not institution, give street and number) MARYLAND ROUTE # 66				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON
Funeral Director	5. Social Security Number 212-64-5826	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 27, 1954	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Washington	10c. City, Town or Location Smithsburg		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 12024 B Wolfsville Road		10f. Zip Code 21783		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction		
	17. Father's Name (First, Middle, Last) Alfred Izak Carter				18. Mother's Name (First, Middle, Maiden Surname) Gladys Mae Carter		
	19a. Informant's Name/Relationship (Type, Print) Gloria Kelly		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12024 B Wolfsville Rd., Smithsburg, Maryland 21783				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens		Date 7/2/99	20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee Raymond Peterson		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Smoke inhalation and thermal injuries Due to (or as a consequence of):						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6-28-99		28b. Time of Injury unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street		28d. Describe how injury occurred Automobile accident and fire 28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 66 Washington County, Maryland			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Stephen S. Radentz, MD		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JUNE 28, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) JUL 02 1999		32. Registrar's Signature B. Spaw					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22014

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mamie Pauline DUNKIN

2. Date of Death

Month Day Year  
JUNE 27 1999

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-09-5607

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth (Month, Day, Year)

Jan. 24, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Route 9, Box 7

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

Collega (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

secretary

16b. Kind of Business/Industry

church

17. Father's Name (First, Middle, Last)

Albert James Wolford

18. Mother's Name (First, Middle, Maiden Surname)

Olive Victoria Crist

19a. Informant's Name/Relationship (Type, Print)

Gladys Campanaro - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5112 Arbutus Ave., Baltimore, Md. 21227-2502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

6-30-99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

*Scott M. Minnich*

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Severe PNEUMONIA

Due to (or as a consequence of):

b.

multiple decubitus ulcers

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Curry*

29c. License number

R 11908

29d. Date signed (Month, Day, Year)

6/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA SARANTE MD MARYLAND GENERAL HOSPITAL

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

*Beverly B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DUN KIN, MAMIE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22015

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Joseph C. Delibert</b>						2. Date of Death Month Day Year <b>June 26, 1999</b>		3. Time of Death <b>3:55 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>						4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>279-01-7598</b>		6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 21, 1914</b>		9. Birthplace (State or Foreign Country) <b>New York</b>	
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3701 International Drive</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Civil Engineer</b>			16b. Kind of Business/Industry <b>Manufacturing</b>		
17. Father's Name (First, Middle, Last) <b>Gondolfo Diliberti</b>						18. Mother's Name (First, Middle, Maiden Summa) <b>Biagia Cerami</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Arthur C. Delibert (son)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 Windermere Court, North Bethesda, MD 20852</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>6-27-99 Beltsville, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. BRAIN STEM STROKE</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. {</b> <b>c. {</b> <b>d. {</b>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>MD 138459</b>		29d. Date signed (Month, Day, Year) <b>JUNE 26, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. GOYAT MD, 1811 Prince Philip Dr, Olney MD 20832</b>									
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Wesley Dodd, Sr.

2. Date of Death

Month Day Year  
June 27, 1999

3. Time of Death

8:34 AM

4a. Facility Name (If not institution, give street and number)

435 West Diamond Avenue, # T2

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

213-10-7799

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 17, 1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

435 West Diamond Avenue, # T2

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Oil Burner Mechanic

16b. Kind of Business/Industry

Heating Company

17. Father's Name (First, Middle, Last)

William

Dodd

18. Mother's Name (First, Middle, Maiden Surname)

Phoebe

Utterbacke

19a. Informant's Name/Relationship (Type, Print)

Alice B. Dodd-Pumphrey/Ex-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

435 West Diamond Ave., # T2, Gaithersburg, MD. 20877

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Forest Oak Cemetery

Date

7/1/1999 Gaithersburg, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Asystole

Due to (or as a consequence of):

1 hour

b. Heart Attack

Due to (or as a consequence of):

1 hour

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Atherosclerosis

Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease

Dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 39372

29d. Date signed (Month, Day, Year)

June 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rashid Baghai, M.D., 344 University Blvd. W., Suite 324, Silver Spring, MD. 20901

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22017

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Karmen

2. Date of Death

Month

Day

Year

3. Time of Death

Dobbs

June

25

1999

7:35 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

429-15-1852

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

3-2-57

9. Birthplace (State or Foreign Country)

Searcy, Arkansas

Usual Residence of Decedent

10a. State

PA

10b. County

Dauphin

10c. City, Town or Location

Lower Paxton Twp.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1125 Center Court, Harrisburg, PA

10f. Zip Code

17111

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Floral Designer

16b. Kind of Business/Industry

Garden Path

17. Father's Name (First, Middle, Last)

Robert Girkin

18. Mother's Name (First, Middle, Maiden Surname)

Peggy Sue Angel

19a. Informant's Name/Relationship (Type, Print)

Mr. Jeff Dobbs (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1125 Center Court Harrisburg, PA 17111

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cremation Society of PA

Date

6-29-99

20c. Location - City or Town, State

4100 Jonestown Rd Harrisburg, PA 17109

21. Signature of Funeral Service Licensee

Evan G. Gregory

22. Name and Address of Facility

Cremation Society of PA

4100 Jonestown Rd, Harrisburg, PA 17109

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiorgan failure

Due to (or as a consequence of):

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Bronchiolitis Obliterans Organizing Pneumonia

Due to (or as a consequence of):

days

c. Allogeneic Bone Marrow Transplant

Due to (or as a consequence of):

66 days

d. Chronic myelogenous leukemia

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sally Ann

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

June 25 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sally Ann Johns Hopkins Hospital Baltimore, MD

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Lucille A. DeLawter

2. Date of Death

June 23, 1999

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

Vindobona Nursing Home

4b. City, Town, or Location of Death

Braddock Heights

4c. County of Death

Frederick

5. Social Security Number

215-14-5954

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 4, 1923

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Braddock Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6012 Jefferson Street

10f. Zip Code

21714

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Switchboard - Receptionist

16b. Kind of Business/Industry

Apartment Building

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Ollie Mae Tanner

19a. Informant's Name/Relationship (Type, Print)

Helen D. Tidwell - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Post Office Box 421, Clarksburg, Maryland 20871

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery

Date

6/26/99

20c. Location - City or Town, State

Cascade, Maryland

21. Signature of Funeral Service Licensee

Olin L. Molesworth

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home  
26401 Ridge Road, Damascus, Maryland

Approximate Interval Between Onset and Death

Within one hour

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

b. Severe critical aortic stenosis

Due to (or as a consequence of):

c. diabetic melicis

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke, chronic asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

NA

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

Chan-Ming Ma Ho, M.D.

29c. License number

D47169

29d. Date signed (Month, Day, Year)

June 25, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Chan-Ming Ma Ho, M.D.

610- 9th Ave., Brunswick, Md. 21716

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Geneva J. Doxzon

2. Date of Death

Month Day Year  
June 27, 1999

3. Time of Death

9:28 pm

4a. Facility Name (If not institution, give street and number)

Shore Nursing Home

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

218-01-8083

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 1, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Hurlock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4013 Wrightswharf Rd.

10f. Zip Code

21643

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Clarence C. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Dayton

19a. Informant's Name/Relationship (Type, Print)

Patricia L. Kiss/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5108 North Dr., Cambridge, MD 21613

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cambridge Crematory 6-28-99 Cambridge, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.

308 High St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease 10y

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicida4 ☐ Homicida5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35284

29d. Date signed (Month, Day, Year)

6/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREA ALONSO 216 S. Washington St Easton MD 21629

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

59 22020

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Belaub ANN Dodson

2. Date of Death  
Month Day Year

6 24 1999

3. Time of Death

0630

4a. Facility Name (If not institution, give street and number)

Chesapeake Woods Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

219-07-7878

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

APR: 17, 1897

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

520 Glenburn Avenue

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Picker

16b. Kind of Business/Industry

Sea Food Industry

17. Father's Name (First, Middle, Last)

Will MAJOR

18. Mother's Name (First, Middle, Maiden Summa)

Nettie Boston

19a. Informant's Name/Relationship (Type, Print)

Corinthian D. Tilghman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

715 Rigby Avenue Cambridge, Maryland 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery

Date

7/01/99 Cambridge, Maryland

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

Henry Funeral Home P.A.  
510 Washington St. Cambridge, MD, 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Debilitated State

Approximate Interval Between Onset and Death

9 mos

Due to (or as a consequence of):

b. Staph Sepsis

6 wks

Due to (or as a consequence of):

c. Hip osteomyelitis

6 wks

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner

29b. Signature and title of certifier

Michael J. Fadden

29c. License number

826388

29d. Date signed (Month, Day, Year)

6/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. FADDEN 302 Collins Ave. Hurler md 21643

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

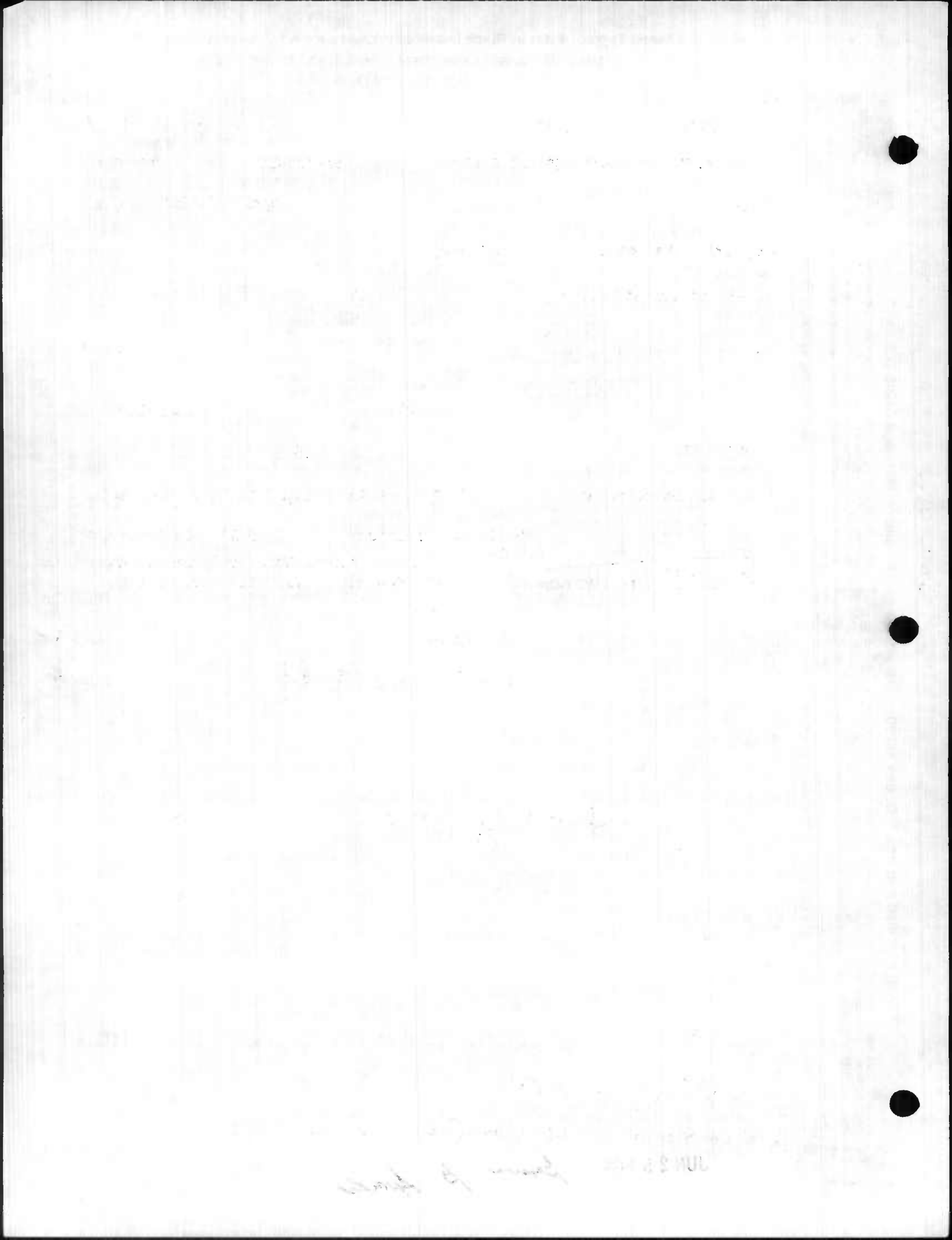
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22021

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JANKI DEVI</b>				2. Date of Death Month Day Year <b>June 24, 1999</b>		3. Time of Death <b>1345</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>None</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b>		8. Date of Birth (Month, Day, Year) <b>April 11, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>India</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>407-F Brookridge Dr., II</b>			
	10f. Zip Code <b>21801</b>				10g. Citizen of What Country? <b>India</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Indian</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Dina Nath</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Durga</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ashok K. Chhibber/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>407F Brookridge Dr., II Salisbury, MD 21801</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Date <b>6/25/99</b>		20d. Location - City or Town, State <b>Salisbury, MD</b>	
	21. Signature of Funeral Service Licensee <b>David H. Thompson</b>		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) a. <b>pneumonia</b> Due to (or as a consequence of):							
	b. <b>Congestive Heart Failure</b> Due to (or as a consequence of):							
	c. <b></b> Due to (or as a consequence of):							
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End-stage kidney failure</b>							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <b>Cynthia J. Tan MD</b>				29c. License number <b>16715</b>		29d. Date signed (Month, Day, Year) <b>6/25/99</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TAD, CONSTANT 547-G Riverside Dr. Salisbury, MD</b>							
3	31. Date filed (Month, Day, Year) <b>JUN 25 1999</b>				32. Registrar's Signature <b>[Signature]</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22022

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sara H. Davis				2. Date of Death Month Day Year JUNE 20 1999		3. Time of Death 9:40 am	
	4a. Facility Name (If not institution, give street and number) Deer's Head Center				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 213-76-1967		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) June 14, 1959	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 315 Deer's Head Hospital RD		10f. Zip Code 21802		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) laborer		16b. Kind of Business/Industry Perdue, Inc.			
	17. Father's Name (First, Middle, Last) Keley Willie Belote				18. Mother's Name (First, Middle, Maiden Surname) Bernice Wessells Drummond			
	19a. Informant's Name/Relationship (Type, Print) Beulah Wilson/sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Elizabeth Street - Salisbury, MD 21804			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State 6/21/99 Salisbury, MD			
	21. Signature of Funeral Service Licenses 				22. Name and Address of Facility Jolley Memorial Chapel MD 21801			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage renal disease Due to (or as a consequence of): b. Diabetes mellitus, Type I Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Coronary artery disease							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe peripheral vascular disease with status post bilateral above the knee amputation, below left elbow amputation.							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier  M.D.				29c. License number DL6003		29d. Date signed (Month, Day, Year) 6/20/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I. J. Hwang, M.D., P.O. Box 2018; Salisbury, Md. 21802							
	31. Date filed (Month, Day, Year) JUN 21 1999				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

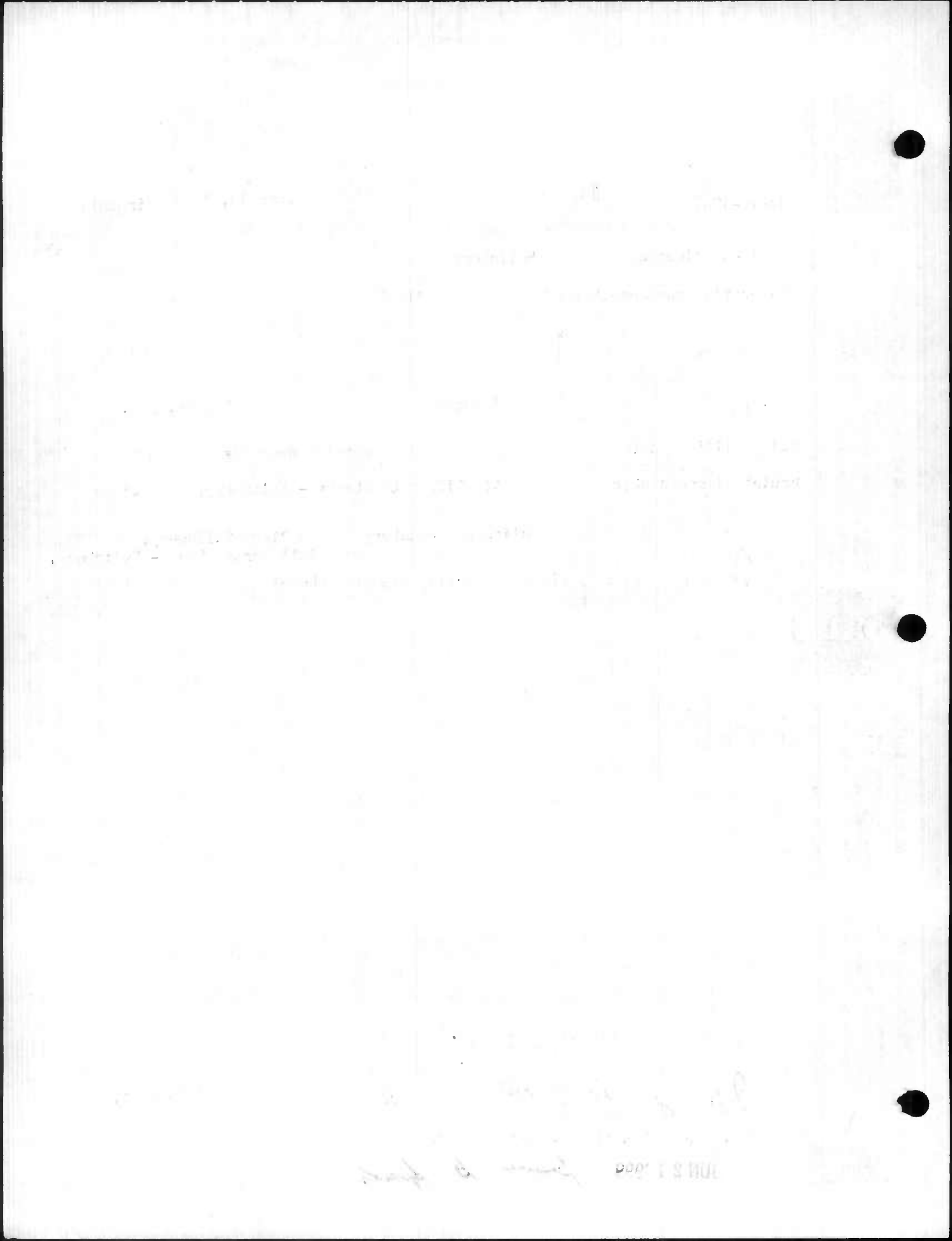
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22023

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ira Eby</b>				2. Date of Death Month <b>June</b> Day <b>28</b> Year <b>1999</b>		3. Time of Death <b>6:30 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>18541 Mason Dixon Rd.</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>		
Funeral Director	5. Social Security Number <b>215-36-7083</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>August 24, 1911</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>18541 Mason Dixon Rd.</b>				10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>		16b. Kind of Business/Industry <b>Agriculture</b>				
	17. Father's Name (First, Middle, Last) <b>Reuben R. Eby</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Horst</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mabel H. Eby</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18541 Mason Dixon Rd. Hagerstown, Md. 21742</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Reiff Mermonite Church Cemetery</b>		Date <b>7/2/99</b>		20c. Location - City or Town, State <b>Cearfoss, Md.</b>		
	21. Signature of Funeral Service Licensee <b>H. Martin Zimmerman</b>				22. Name and Address of Facility <b>Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Congestive heart failure</b> Due to (or as a consequence of): b. <b>Arteriosclerotic heart disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <b>Charles C. Spencer, MD</b>	
29c. License number <b>D11133</b>				29d. Date signed (Month, Day, Year) <b>June 29, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles C. Spencer 11110 Medical Campus Rd Hagerstown MD 21742</b>									
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>				32. Registrar's Signature <b>Anna G. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 900-83.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The purpose of this report is to provide information on the results of the study conducted by the author.

2.

3. The study was conducted in the following manner:

4. The results of the study are as follows:

5. The following table shows the results of the study:

6. The following table shows the results of the study:

7. The following table shows the results of the study:

8. The following table shows the results of the study:

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41. The following table shows the results of the study:

42. The following table shows the results of the study:

43. The following table shows the results of the study:



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22024

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE MARTHA ENGLER

2. Date of Death

Month Day Year  
JUNE 27, 1999

3. Time of Death

4:33 AM

4a. Facility Name (If not institution, give street and number)

1900 WALLACE AVE.

4b. City, Town, or Location of Death

WHEATON

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

385-40-3242

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 15, 1923

9. Birthplace (State or Foreign Country)

DRESDEN, GERMANY

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

WHEATON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

1900 WALLACE AVE.

10f. Zip Code

20902-1302

10g. Citizen of What Country?

GERMANY

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

TEACHER-INVESTOR

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

EMIL GEORGI

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA SCHMIDT

19a. Informant's Name/Relationship (Type, Print)

RENATA ENGLER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1900 WALLACE AVE., WHEATON, MD, 20902-1302

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

7/1/99

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

M. M. Chambers MO0091

CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20906

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Aspiration pneumonia and Respiratory Arrest  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death10 days  
+ yrs.Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Diagnosis of unknown etiology Alzheimer type  
with Parkinson Disease (Progressive disease)  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute vasculitis etiology unknown  
with concurrent syndrome of both hands.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)  
NA28b. Time of  
Injury

NA M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

NA

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

NA

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

NA

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harry C. Holloway

29c. License number

7213 State of Okla.

29d. Date signed (Month, Day, Year)

28 June 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

USUHS Dept. of Psychiatry, 4301 Jones Bridge Rd Bethesda MD 20813

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

Jennifer B. Sparks

State  
RegistrarDivision of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



99 22025

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Helen Louise Fenwick</b>				2. DATE OF DEATH MONTH <b>6</b> DAY <b>27</b> YEAR <b>99</b>		3. TIME OF DEATH <b>8:10 PM</b>	
4. SOCIAL SECURITY NUMBER <b>218-30-4724</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-4-1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Mary's Nursing Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Leonardtown, Md</b>	
9c. COUNTY OF DEATH <b>St. Mary's</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>St. Mary's</b>	
10c. CITY, TOWN OR LOCATION <b>St. Inidgoes</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>48425 Beachville Road</b>	
10f. ZIP CODE <b>20684</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Christopher Columbus Butler</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Theresa Barnes Butler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Melody Fenwick - Daughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3387 Ryon Court; Waldorpha, MD 20601</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Nat'l Harmony Memorial Park</b>		20c. LOCATION — City or Town, State <b>Landover, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John A. Spinks Jr.</i> <b>CC0348</b>				22. NAME AND ADDRESS OF FACILITY <b>Latney's Funeral Home</b> <b>3831 Georgia Ave NW; Wash., DC 20011</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiac arrest</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>End stage CAD.</b>							
c. <b>End stage CHF</b>							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. D. Shah</i>				29c. LICENSE NUMBER <b>DH7066</b>		29d. DATE SIGNED (Month, Day, Year) <b>6-28-99</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.D. SHAH P.O. BOX 664 Leonardtown, Md. 20650</b>							
31. DATE FILED (Month, Day, Year) <b>JUN 30 1999</b>				32. REGISTRAR'S SIGNATURE <i>Barbara B. Sparks</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22026

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SYLVIA FISHER				2. Date of Death Month: 06, Day: 27, Year: 1999		3. Time of Death 1:40 AM	
	4a. Facility Name (If not institution, give street and number) BROOKE GROVE REHABILITATION CENTER				4b. City, Town, or Location of Death SANDY SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 577.10.7218		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) 01.24.1909	
	9. Birthplace (State or Foreign Country) OHIO		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SANDY SPRING	
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 18430 BROOKE GROVE ROAD		10f. Zip Code 20860	
	10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (14 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PIANIST		16b. Kind of Business/Industry SELF EMPLOYED	
	17. Father's Name (First, Middle, Last) SAMUEL PHILLIPSON		18. Mother's Name (First, Middle, Maiden Surname) FANNIE SILVER		19a. Informant's Name/Relationship (Type, Print) PEARLE MILLER/SISTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15101 INTERLACHEN DRIVE #703, SILVER SPRING, MD 20906	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEMTR.		20c. Location - City or Town, State ALEXANDRIA, VA		20d. Date 07.02.99	
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE RENAL FAILURE Due to (or as a consequence of): b. DEHYDRATION Due to (or as a consequence of): c. HYPONATREMIA Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death DAYS DAYS 1 WEEK	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE; CHRONIC OBSTRUCTIVE PULMONARY DISEASE		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify):		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. S. MUMFORD STAFF PHYSICIAN		29c. License number D42046	
29d. Date signed (Month, Day, Year) JUNE 27, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND 20860		31. Date filed (Month, Day, Year) JUN 30 1999		32. Registrar's Signature Benita B. Sparks		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22027

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT H. FISK

2. Date of Death

JUNE 26, 1999

3. Time of Death

7:15 AM

4a. Facility Name (If not institution, give street and number)

14812 HAROLD ROAD

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

001 12 5556

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 29, 1919

9. Birthplace (State or Foreign Country)

VERMONT

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14812 HAROLD ROAD

10f. Zip Code

20905

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SYSTEMS ANALYST

16b. Kind of Business/Industry

COMPUTER INDUSTRY

17. Father's Name (First, Middle, Last)

HAROLD FISK

18. Mother's Name (First, Middle, Maiden Surname)

EDITH CROLIUS

19a. Informant's Name/Relationship (Type, Print)

JANET D. TUNNEY, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14812 HAROLD ROAD, SILVER SPRING, MD. 20905

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

LAYTONSVILLE CEMETERY

Date

6/29/99

20c. Location - City or Town, State

LAYTONSVILLE, MD.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME  
P.O. BOX 5038, LAYTONSVILLE, MD. 2088223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. MULTIPLE MYELOMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Chris Lynn M.D.

29c. License number

MARYLAND  
42452

29d. Date signed (Month, Day, Year)

JUNE 28, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. CHITRA RAJA KOPPEL, M.D.  
18111, PRINCE PHILIP DRIVE, #327, OLNEY, MD 20832

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22028

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Paolo Ferrara</b>				2. Date of Death Month <b>June</b> Day <b>24</b> Year <b>1999</b>				3. Time of Death <b>3:57pm</b>	
4a. Facility Name (If not institution, give street and number) <b>5988 Cecil Way</b>				4b. City, Town, or Location of Death <b>Eldersburg</b>				4c. County of Death <b>Carroll</b>	
5. Social Security Number <b>216-76-5394</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>55</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 8 1944</b>		9. Birthplace (State or Foreign Country) <b>Italy</b>	
Usual Residence of Decedent									
10a. State <b>Md</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Eldersburg</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>5988 Cecil Way</b>				10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>electrician</b>			16b. Kind of Business/Industry <b>construction</b>		
17. Father's Name (First, Middle, Last) <b>Girolamo Ferrara</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Giovanna Tazza</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Elvira Ferrara (spouse)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5988 Cecil Way, Eldersburg, Md 21784</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springfield Cemetery</b>		Date <b>6-27-99</b>		20c. Location - City or Town, State <b>Sykesville, Md</b>			
21. Signature of Funeral Service Licensee <b>Brian D. Haight</b>				22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, Md 21784</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. metastatic melanoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>6 months</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Jerome H. Ginsberg, M.D.</b>				29c. License number <b>D0020964</b>		29d. Date signed (Month, Day, Year) <b>June 26, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133</b>									
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature <b>Benita B. Sparks</b>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22029

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) HARRY L. GERWIN  
2. Date of Death Month Day Year JUNE 27, 1999  
3. Time of Death 6:50AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 14305 ANSTED ROAD  
4b. City, Town, or Location of Death SILVER SPRING  
4c. County of Death MONTGOMERY

5. Social Security Number 486-12-2264  
6. Sex ☒ M ☐ F  
7. Age (In yrs. last birthday) 84 Yrs.  
8. Date of Birth (Month, Day, Year) FEB. 2, 1915  
9. Birthplace (State or Foreign Country) MISSOURI

Usual Residence of Decedent  
10a. State MARYLAND  
10b. County MONTGOMERY  
10c. City, Town or Location SILVER SPRING  
10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 14305 ANSTED ROAD  
10f. Zip Code 20905  
10g. Citizen of What Country? UNITED STATES

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No) ☐ Yes ☒ No  
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICAL ENGINEER  
16b. Kind of Business/Industry FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last) KARL GERWIN  
18. Mother's Name (First, Middle, Maiden Surname) WOBBIENE JUTTING

19a. Informant's Name/Relationship (Type, Print) PAT SCHAAP/DAUGHTER  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13019 TRIDELPHIA MILL RD. CLARKSVILLE, MD 21029

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) UNION CEMETERY  
20c. Location - City or Town, State 7/1/99 BURTONSVILLE, MD

21. Signature of Funeral Service Licensee  
22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC.  
11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) PANCREATIC CARCINOMA  
Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  
Due to (or as a consequence of):  
Approximate Interval Between Onset and Death FROM ITH

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No  
26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined  
28a. Date of Injury (Month, Day Year)  
28b. Time of Injury M  
28c. Injury at Work? ☐ Yes ☒ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
29c. License number 00051865  
29d. Date signed (Month, Day, Year) JUNE 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEEPAK CUDDAPAH, MD 3905 NATIONAL DRIVE SUITE 220 BURTONSVILLE, MD 20866

31. Date filed (Month, Day, Year) JUL 02 1999  
32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22030

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES WATERS GILCHRIST

2. Date of Death

Month Day Year  
JUNE 24 1999

3. Time of Death

2300

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

217-34-1460

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 12, 1936

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

250 South President Street, #1300

10f. Zip Code

21202

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1961-

If Yes, Give

Year or Dates: 1962

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Episcopal Priest

16b. Kind of Business/Industry

Episcopal Church

17. Father's Name (First, Middle, Last)

Ralph A. Gilchrist

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Waters

19a. Informant's Name/Relationship (Type, Print)

Phoebe R. Gilchrist/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

250 South President St., #1300, Baltimore, MD 21202

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

June 27, 1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

David E. Perry M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave.

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC ADENOCARCINOMA

2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David E. Perry MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JUNE 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID ZAAS, JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

David E. Perry

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

19+




Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22031

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ARCHIE GINN</b>				2. Date of Death Month Day Year <b>JUNE 23, 1999</b>		3. Time of Death <b>6:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Potomac Valley Nursing &amp; Wellness</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>568-22-9341</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 14, 1925</b>	9. Birthplace (State or Foreign Country) <b>California</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>6834 Old Stage Road</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>45-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Chinese</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>			16b. Kind of Business/Industry <b>Dept. of Commerce</b>		
17. Father's Name (First, Middle, Last) <b>Unknown</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Gin Lee See</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Aurora H.S. Ginn (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6834 Old Stage Rd., Rockville, MD 20852</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Mem. Park</b>		Date <b>7/2/99</b>		20c. Location - City or Town, State <b>Rockville, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Renal Failure</b>  Due to (or as a consequence of): <b>Arteriosclerotic vascular disease</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Diabetis Mellitus</b>  Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>6 months</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and Title of Certifier 	
			29c. License number <b>D01120</b>				29d. Date signed (Month, Day, Year) <b>6/24/99</b>		
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <b>Walter E. Goosz, M.D. 1299 Lamberton Drive, Silver Spring, MD 20902</b>									
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10





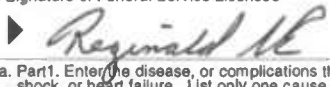

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22032

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Gordon</b>				2. Date of Death Month <b>June</b> Day <b>26</b> Year <b>1999</b>				3. Time of Death <b>2 AM.</b>																																																																
	4a. Facility Name (If not institution, give street and number) <b>Hebrew Home of Greater Washington</b>				4b. City, Town, or Location of Death <b>Rockville</b>				4c. County of Death <b>Montgomery</b>																																																																
Funeral Director	5. Social Security Number <b>020-30-9350</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 2, 08</b>		9. Birthplace (State or Foreign Country) <b>Massachusetts</b>																																																																
	Usual Residence of Decedent																																																																								
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																																																	
10e. Street and Number <b>6121 Montrose Rd.</b>				10f. Zip Code <b>20852</b>				10g. Citizen of What Country? <b>United States</b>																																																																	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																																																																	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookkeeper</b>				16b. Kind of Business/Industry <b>Private</b>																																																																	
17. Father's Name (First, Middle, Last) <b>Hyman Rower</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dora Cullen</b>																																																																					
19a. Informant's Name/Relationship (Type, Print) <b>Martin E. Gordon/son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2624 Spencer Rd. Chevy Chase, MD. 20815</b>																																																																					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Memorial</b>		Date <b>6/27</b>		20c. Location - City or Town, State <b>Olney, MD.</b>																																																																	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Takoma Funeral Home. 254 Carroll St. NW. Washington, DC 20012</b>																																																																					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																																									
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td colspan="8"><b>Sepsis</b></td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="8"><b>Gangrene Right leg</b></td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="8"><b>Peripheral vascular disease</b></td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="8"></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Sepsis</b>								Due to (or as a consequence of):									b.	<b>Gangrene Right leg</b>								Due to (or as a consequence of):									c.	<b>Peripheral vascular disease</b>								Due to (or as a consequence of):									d.								
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Sepsis</b>																																																																							
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																																																																	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																																																			
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29b. Signature and title of certifier  <b>Gregory A. Compton MD</b>				29c. License number <b>D24942</b>				29d. Date signed (Month, Day, Year) <b>June 26 1999</b>																																																																	
30. Name and address of person who completed cause of death (item 23e) (Type, Print) <b>GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD</b>																																																																									
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature 																																																																							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22033

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) Willie B Gosha				2. Date of Death Month: June Day: 26 Year: 1999				3. Time of Death 2:00	
4a. Facility Name (If not institution, give street and number) 18633 Sandpiper Lane				4b. City, Town, or Location of Death Gaithersburg				4c. County of Death Montgomery	
5. Social Security Number 420-44-4752		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 7, 1935		9. Birthplace (State or Foreign Country) Alabama	
Usual Residence of Decedent									
10a. State MD		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 18633 Sandpiper Lane				10f. Zip Code 20879		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Utility Worker			16b. Kind of Business/Industry Food Service		
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Charles Mae Gosha					
19a. Informant's Name/Relationship (Type, Print) Sharleta Gosha-Duvall (Dau)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16109 Crabbs Branch Way, Rockville, MD 20855					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Emory Grove Cemetery		Data 7/3/99		20c. Location - City or Town, State Gaithersburg, MD			
21. Signature of Funeral Service Licensee George R. Snowden				22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature] (One)				29c. License number 015236		29d. Date signed (Month, Day, Year) JUNE 26, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL E. MARCOIS, MD. (One) 1125 Rockville Pike, Rockville, MD 20852									
31. Date filed (Month, Day, Year) JUN 29 1999		32. Registrar's Signature [Signature] B. Sparks							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified immediately.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22036

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Grant

2. Date of Death

June 27, 1999

Day

Year

3. Time of Death

0915 A

4a. Facility Name (If not institution, give street and number)

Shady Grove Rehabilitation Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

004-09-7583

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sep. 1, 1914

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Florida

10b. County

Broward

10c. City, Town or Location

Ft. Lauderdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2200 S. Ocean Lane

10f. Zip Code

33316

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Real Estate Manager

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Morris Grant

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Stillman

19a. Informant's Name/Relationship (Type, Print)

Paul E. Grant/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 2341, Arlington, VA 22202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gardens

Date

June 28, 1999

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Danzansky-Goldberg Memorial Chapels, Inc.  
1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recurrent dehydration, hip fracture, dementia,  
rheumatoid arthritis, anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Physician

29c. License number

D0052255

29d. Date signed (Month, Day, Year)

June 27, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Muhammad Ejaz M.D. 8609 2nd Ave #404 B Silver Spring MD. 20910

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22035

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Catherine Graves				2. Date of Death Month Day Year June 24, 1999				3. Time of Death 2:30 AM	
	4a. Facility Name (If not institution, give street and number) Care Matrix Nursing Home				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 215-52-8829		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) June 26, 1948		9. Birthplace (State or Foreign Country) Massachusetts	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Wheaton				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 11500 Galt Ave				10f. Zip Code 20902		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry US Postal Service		
	17. Father's Name (First, Middle, Last) Richard Dwight Johnston				18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Connellee					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Mary R. Ventura/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11500 Galt Ave, Wheaton, MD 20902					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Darlington Cemetery		Date Jun 30		20c. Location - City or Town, State Darlington, MD			
	21. Signature of Funeral Service Licensee Alan J. Danell				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Squamous Cell Carcinoma of the Throat Due to (or as a consequence of): Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D33159		29d. Date signed (Month, Day, Year) June 25, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruth Kevers-Cohen 8700 Georgia Ave, #400, Silver Spring, MD 20910									
	31. Date filed (Month, Day, Year) JUN 28 1999		32. Registrar's Signature Gene B. Sparks							





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State of Maryland / Department of Health and Mental Hygiene

99-22036

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Frederick Galen Jr.</b>				2. Date of Death Month Day Year <b>June 26, 1999</b>		3. Time of Death <b>4:25pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>004-24-1019</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 11, 1928</b>	9. Birthplace (State or Foreign Country) <b>Maine</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Brookeville</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
10e. Street and Number <b>18556 Queen Elizabeth Drive</b>				10f. Zip Code <b>20833</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1946-1976</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>2</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Project Administrator</b>			16b. Kind of Business/Industry <b>Bechtel</b>	
17. Father's Name (First, Middle, Last) <b>James Frederick Galen, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary McPhee</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ellen Galen (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18556 Queen Elizabeth Drive, Brookeville, MD 20833</b>				
20e. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>6/27/99</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 East Deer Park Drive</b> <b>Gaithersburg, MD 20877</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Necrotizing Pseudomonas pneumonia</b>  Due to (or as a consequence of): <b>CHRONIC OBSTRUCTIVE pulmonary disease</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Supraventricular TACHY-CARDIA,</b> <b>Aortic Tubular Necrosis with Renal Failure</b>								Approximate Interval Between Onset and Death <b>8 weeks</b> <b>15 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Supraventricular TACHY-CARDIA,</b> <b>Aortic Tubular Necrosis with Renal Failure</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)						
27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred
29e. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>023630</b>		29d. Date signed (Month, Day, Year) <b>JUNE 27, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frank J. MAYO, MD 16820 Frederick Road #213, Gaithersburg, MD 20877</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint, illegible handwritten text throughout the page]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22037

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rosalinda Gamez

2. Date of Death

June 22, 1999

3. Time of Death

0431

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

28

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 3, 1970

9. Birthplace (State or Foreign Country)

Mexico

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

8403 Barron Street

10f. Zip Code

20912

10g. Citizen of What Country?

Mexico

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify: Mexican14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Victor Gamez

18. Mother's Name (First, Middle, Maiden Surname)

Amada Guerrero

19a. Informant's Name/Relationship (Type, Print)

Jesus Gamez (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8403 Barron Street, Takoma Park, MD 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Panteon Municipal Cemetery 1999

Date

June 30

20c. Location - City or Town, State

Cerritos, San Luis Potosi, Mexico

21. Signature of Funeral Service Licensee

Eric L. Sparks

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd. W, Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Seizure Disorder

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Eric L. Sparks

29c. License number

D15236

29d. Date signed (Month, Day, Year)

June 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carl Margolis, MD 11125 Rockville Pike, Rockville, MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

Eric L. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


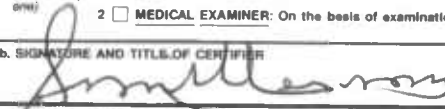
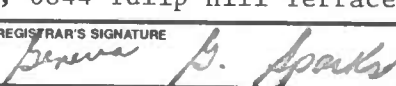


99 22030

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Eleanor M. Gaud				2. DATE OF DEATH MONTH DAY YEAR June 29, 1999				3. TIME OF DEATH 2:10 PM M			
4. SOCIAL SECURITY NUMBER 068-22-8644		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1909		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) Springhouse Manor Care - Westwood				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5101 Ridgefield Road				10f. ZIP CODE 20816		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) William Mason Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Allen Evans							
19a. INFORMANT'S NAME (Type/Print) Anne Gaud Tinker (daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5212 Westwood Drive, Bethesda, Maryland 20816							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		DATE 6-30		20c. LOCATION — City or Town, State Beltsville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): c. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death days 8 days Years											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Memory Loss, Gastroesophageal Reflux Disease, Mitral Valve Prolapse, Coronary Artery Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living Facility									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D35579		29d. DATE SIGNED (Month, Day, Year) June 29, 1999					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Maryland 20816											
31. DATE FILED (Month, Day, Year) JUN 30 1999				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22039

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Lee Green				2. Date of Death Month Day Year June 28 1999				3. Time of Death 21:20	
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll	
Funeral Director	5. Social Security Number 214-03-1505		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Jan 6 1909		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md		10b. County Carroll		10c. City, Town or Location Sykesville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 626 Conaway Lane				10f. Zip Code 21784		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) coal miner			16b. Kind of Business/Industry mining		
	17. Father's Name (First, Middle, Last) John Adam Green				18. Mother's Name (First, Middle, Maiden Surname) Alda Broadwater					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lucy H. Green (spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 626 Conaway Lane, Sykesville, Md 21784					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial		Date 7-2-99		20c. Location - City or Town, State Sykesville, Md			
	21. Signature of Funeral Service Licensee Paige Haight Herbert				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary arrest Due to (or as a consequence of): b. anoxic encephalopathy Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 2 days 2 days	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Lisa Kim, M.D.		29c. License number D 52479		29d. Date signed (Month, Day, Year) June 28, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LISA Kim, MD. at Carroll County General Hospital at 200 Memorial Avenue, Westminster, MD 21157		31. Date filed (Month, Day, Year) JUN 30 1999		32. Registrar's Signature Benita B. Sparks						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter Gerald Gibson

2. Date of Death

Month Day Year  
July 1, 1999

3. Time of Death

3:35 AM

4a. Facility Name (If not institution, give street and number)

23600 Founders Place

4b. City, Town, or Location of Death

Damascus

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

212-44-2600

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 16, 1945

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23600 Founders Place

10f. Zip Code

20872

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1974-78

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Nuclear Physicist

16b. Kind of Business/Industry

U.S. Department of Energy

17. Father's Name (First, Middle, Last)

Walter M. Gibson, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Tally

19a. Informant's Name/Relationship (Type, Print)

Jane K. Gibson - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23600 Founders Place, Damascus, Maryland 20872

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crestlawn Memorial Gardens 7/3/99 Marriottsville, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Rout L. Williams

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home  
26401 Ridge Road, Damascus, Maryland 20872-0117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Colon Cancer

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombophlebitis  
Pulmonary Emboli

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel Rosenblum MD

29c. License number

D04766

29d. Date signed (Month, Day, Year)

7-1-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Daniel Rosenblum, M.D. 10400 Conn. Ave., Suite 606, Kensington, Md. 20895

31. Date filed (Month, Day, Year)

Jul 02 1999

32. Registrar's Signature

B. Apak

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

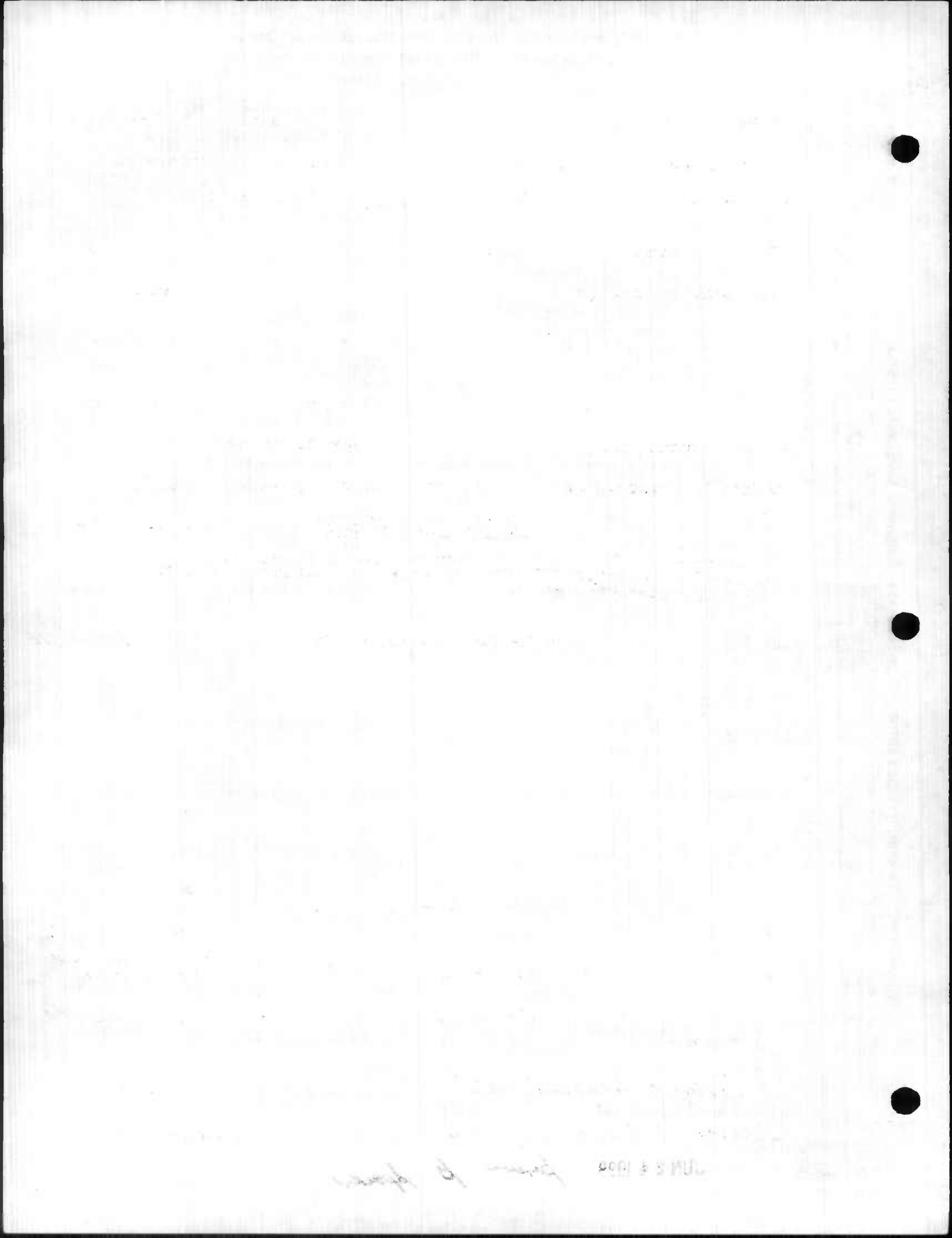
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Vincena J. Garner</b>						2. Date of Death Month <b>June</b> Day <b>21</b> Year <b>1999</b>		3. Time of Death <b>4:52 A.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Route 13 near Sheephouse Road</b>						4b. City, Town, or Location of Death <b>Pocomoke</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>061-70-1476</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>28</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 21, 1971</b>		9. Birthplace (State or Foreign Country) <b>NC</b>	
	Usual Residence of Decedent									
10a. State <b>NY</b>		10b. County <b>Kings</b>		10c. City, Town or Location <b>Brooklyn</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>830 Putnam Avenue, Apt. 1</b>				10f. Zip Code <b>11226</b>		10g. Citizen of What Country? <b>U.S.</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Clerk</b>			16b. Kind of Business/Industry <b>Healthcare</b>			
17. Father's Name (First, Middle, Last) <b>Bruce S. Garner, Jr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Juanita Townsend</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Juanita T. Garner/mother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>H120 Kings Arrow Rd., Budlake, NJ 07828</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Center Grove Missionary Baptist Church Cemetery</b>		20c. Date <b>6/26/99</b>		20d. Location - City or Town, State <b>Red Springs, NC</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>MASSIVE HEAD INJURY</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>IMMEDIATE</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>RT 13 Budlake</b>								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>6-21-99</b>		28b. Time of Injury <b>4:52 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>VEHICLE RAN OFF ROAD INTO A TREE</b>		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>U.S. RT. 13</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>RT 13 Pocomoke, MD.</b>								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Dorothy C. Holzworth, M.D.</b>						29c. License number <b>D06241</b>		29d. Date signed (Month, Day, Year) <b>6-23-99</b>		
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) <b>Dorothy C. Holzworth, M.D., 203 Snow St. Snow Hill, MD 21863</b>										
31. Date filed (Month, Day, Year) <b>JUN 24 1999</b>				32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nastassia V. Garner</b>				2. Date of Death Month <b>June</b> Day <b>21</b> Year <b>1999</b>				3. Time of Death <b>4:52 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Route 13 near Sheephouse Road</b>				4b. City, Town, or Location of Death <b>Pocomoke</b>				4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>1</b> Months <b>15</b> Days		8. Date of Birth (Month, Day, Year) <b>May 6, 1999</b>		9. Birthplace (State or Foreign Country) <b>NY</b>		
	Usual Residence of Decedent										
10a. State <b>NY</b>		10b. County <b>Kings</b>		10c. City, Town or Location <b>Brooklyn</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>830 Putnam Ave., Apt. 1</b>				10f. Zip Code				10g. Citizen of What Country? <b>U.S.</b>			
11. Marital Status <b>n/a</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>n/a</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>n/a</b> College (1-4 or 5+) <b>n/a</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>n/a</b>				16b. Kind of Business/Industry <b>n/a</b>			
17. Father's Name (First, Middle, Last) <b>Maurice Truitt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Vincena Garner</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Juanita T. Garner/grandmother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>H120 Kings Arrow Rd., Budlake, NJ 07828</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Center Grove Missionary Baptist Church Cemetery</b>				20c. Location - City or Town, State <b>6/26/99 Red Springs, NC</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lewis N. Watson Funeral Home</b> <b>1618 West Rd., Salisbury, MD 21801</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CERVICAL FRACTURE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>IMMEDIATE</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Rt. 13 Pocomoke</b>							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>6-21-99</b>		28b. Time of Injury <b>4:52 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				28d. Describe how injury occurred <b>VEHICLE RAN OFF ROAD INTO A TREE</b>							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>U.S. Rt. 13</b>							
				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Rt. 13 Pocomoke, MD</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Dorothy C. Holzworth, M.D.</b>		29c. License number <b>D 06241</b>		29d. Date signed (Month, Day, Year) <b>6-23-99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD 21863</b>											
31. Date filed (Month, Day, Year) <b>JUN 24 1999</b>				32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar

100-2-100  
JUN 2 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-22043

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mattie Garner</b>				2. Date of Death Month Day Year <b>June 21 1999</b>				3. Time of Death <b>4:52 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Route 13 near Sheepphouse Road</b>				4b. City, Town, or Location of Death <b>Pocomoke</b>				4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number <b>228-32-1420-A</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 12, 1926</b>		9. Birthplace (State or Foreign Country) <b>VA</b>		
	Usual Residence of Decedent				10c. City, Town or Location <b>Murfreesboro</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10a. State <b>NC</b>		10b. County <b>Hertford</b>		10e. Street and Number <b>100 Garner Drive</b>				10f. Zip Code <b>27855</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>5</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>				16b. Kind of Business/Industry <b>Education</b>			
17. Father's Name (First, Middle, Last) <b>Ralph Augustus Wilson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hattie Fuller</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Lorraine W. Brown/sister-in-law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>108 Garner Drive, Murfreesboro, NJ 27855</b>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gatling Cemetery</b>				Date <b>6/26/99</b>		20c. Location - City or Town, State <b>Mapleton, NC</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. MASSIVE HEAD INJURY</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>IMMEDIATE</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Rt. 13 Pocomoke</b>							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) <b>6-21-99</b>		28b. Time of Injury <b>4:52 M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>INTO A TREE VEHICLE RAN OFF ROAD</b>	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>U.S. Rt. 13</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Rt. 13 Pocomoke, MD.</b>			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 						29c. License number <b>D06241</b>		29d. Date signed (Month, Day, Year) <b>6-23-99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dorothy C. Holzworth, M.D. 203 Snow St. Snow Hill, MD 21863</b>											
31. Date filed (Month, Day, Year) <b>JUN 24 1999</b>				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22044

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bruce S. Garner, Sr.				2. Date of Death Month Day Year June 21, 1999				3. Time of Death 4:52 A.M.			
	4a. Facility Name (If not institution, give street and number) Route 13 near Sheephouse Road				4b. City, Town, or Location of Death Pocomoke				4c. County of Death Worcester			
Funeral Director	5. Social Security Number 230-14-6714		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Aug 6, 1926		9. Birthplace (State or Foreign Country) VA			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State NC		10b. County Hertford		10c. City, Town or Location Murfreesboro				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 100 Garner Drive				10f. Zip Code 27855		10g. Citizen of What Country? U.S.					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warrant Officer				16b. Kind of Business/Industry Law Enforcement			
	17. Father's Name (First, Middle, Last) Fitzhugh Garner				18. Mother's Name (First, Middle, Maiden Surname) Rita Williams							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lorraine W. Brown/sister-in-law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Garner Drive, Murfreesboro, NJ 27855							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gatling Cemetery		Date 6/26/99		20c. Location - City or Town, State Mapleton, NC					
	21. Signature of Funeral Service Licensed				22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6/21/99		28b. Time of Injury 0452 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Driver in auto accident				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street				28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt 13/Sheephouse Rd						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) June 22, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201												
31. Date filed (Month, Day, Year) JUN 24 1999		32. Registrar's Signature [Signature]										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Handwritten signature or initials.



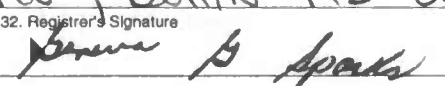
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARION JEAN GUERRIERI</b>				2. Date of Death Month Day Year <b>June 22, 1999</b>		3. Time of Death <b>8:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>203A S. Heron Dr.</b>				4b. City, Town, or Location of Death <b>Ocean City</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>171-26-2207</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 5, 1915</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Ocean City</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>203A S. Heron Dr.</b>		10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cleaning Service Employee</b>		16b. Kind of Business/Industry <b>Dry Cleaners</b>		16c. Kind of Business/Industry <b>Dry Cleaners</b>		
17. Father's Name (First, Middle, Last) <b>Robert Hamilton Patton</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jane Wilson</b>		19a. Informant's Name/Relationship (Type, Print) <b>Phyllis J. Schwarzmann/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>144 E. Main St., Ligonier, PA 15658</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Ann's Cemetery</b>		20c. Date <b>6/26/99</b>		20d. Location - City or Town, State <b>Wilpen, PA</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association</b> <b>501 Snow Hill Rd., Salisbury, MD 21804</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Adenocarcinoma of the LUNG</b> Due to (or as a consequence of): b. <b>Malnutrition</b> Due to (or as a consequence of): c. <b>Metastatic Cancer Lymphogenous Spread from Lung</b> Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>June 22, 1999</b>		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>H0053775</b>		29d. Date signed (Month, Day, Year) <b>6/23/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>11107 Racetrack Rd, Berlin MD 21811</b>		31. Date filed (Month, Day, Year) <b>JUN 23 1999</b>		32. Registrar's Signature 		33. State Registrar <b>Dr. Faith Jabers</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

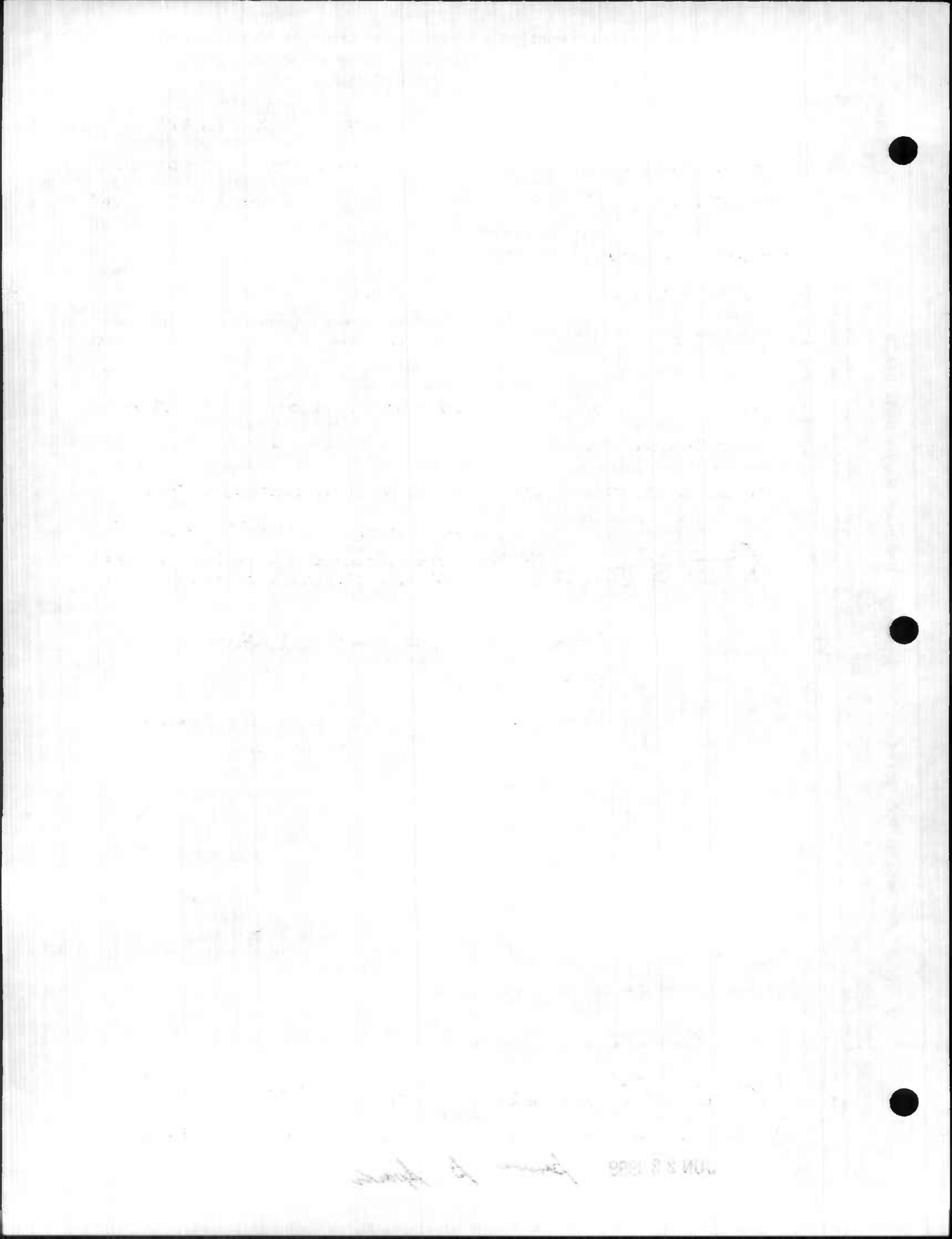
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



*[Faint handwritten mark]*

JUN 2 1966

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH	
Carl Thurston HIGGS				June 28 1999				10:10 A. M.	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
214-09-1353		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		82 YRS.		Sept. 28 1916		Maryland	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH	
152 Buttercup Drive				Hagerstown				Washington	
RESIDENCE OF DECEDENT									
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
Maryland		Washington		Hagerstown				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?	
152 Buttercup Drive				21740				U.S.A.	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. RACE — American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY	
Elementary/Secondary (0-12)		College (1-4 or 5+)		Senior Test Engineer				Truck Manufacturer	
12		2							
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
Carl Amos Higgs				Ethel Lillian Miller					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Rachel Higgs - Wife				152 Buttercup Drive Hagerstown, Maryland 21740					
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				Brownsville Cemetery 7/1/99				Brownsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY					
				Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								9 months	
a. METASTATIC ADENOCARCINOMA OF UNKNOWN PRIMARY									
DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?	
PROSTATE CARCINOMA HYPERTENSION BRIAR FIRMATION DIABETES MELLITUS								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)					
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one)									
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)	
				D38892				6/29/99	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
PAMELA FOX BRADFORD MD SUITE 130 HAGERSTOWN, MD 21742									
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE					
JUN 30 1999									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22047

Helmer, Marian Victoria

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Marian Victoria HELMER</b>						2. Date of Death Month <b>June</b> Day <b>29</b> Year <b>1999</b>		3. Time of Death <b>14:44 pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>			
5. Social Security Number <b>579-12-8580</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 6 1917</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>12 S. Walnut Street #210</b>				10f. Zip Code <b>21740</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Her own home</b>		
17. Father's Name (First, Middle, Last) <b>Charles Shipp</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Nina (unknown)</b>				
19a. Informant's Name/Relationship (Type, Print) <b>J. W. Helmer, Jr. - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1150 Kenly Avenue #12 Hagerstown, Md. 21740</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery</b>			Date <b>7/1/99</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>Cardiopulmonary arrest</b> immediate Due to (or as a consequence of): b. <b>massive intestinal hemorrhage and</b> few days Due to (or as a consequence of): c. <b>gangrene of bowels</b> Due to (or as a consequence of): d. <b>senility and osteoporosis</b>									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>014800</b>		29d. Date signed (Month, Day, Year) <b>6, 20, 99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MASSOUD B. ALIZADEH, MD. 240 Frederick St Hagerstown MD 21740</b>									
31. Date filed (Month, Day, Year) <b>6, 30, 1999</b>			32. Registrar's Signature 						

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22048

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JESSIE HANKS

2. Date of Death

Month Day Year  
JUNE 28 1999

3. Time of Death

7:41AM

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

5. Social Security Number

252 48 1416

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT 24 1931

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD.

10b. County

P.G.

10c. City, Town or Location

HYATTSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6040 SARGENT ROAD

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

CONSTRUCTION WORKER

16b. Kind of Business/Industry

PVT.

17. Father's Name (First, Middle, Last)

ALBERT HANKS SR.

18. Mother's Name (First, Middle, Maiden Surname)

LUCILLE CLARK

19a. Informant's Name/Relationship (Type, Print)

CLIFFORD HANKS/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6002 SPRINGHILL DR. #201 GREENBELT, MD. 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEM.

Date

7/2/99

20c. Location - City or Town, State

BRENTWOOD, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WATSON F. H. INC.

3435 14th ST., N.W. 20010

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE.

Due to (or as a consequence of):

b. SEVERE CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

① severe cardiomyopathy  
 ② valvular heart disease ③ Diabetes mellitus  
 ④ Prostate Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D24593

29d. Date signed (Month, Day, Year)

6.28.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMED A. MANNAN MD. 3331 - TOLEDO TERRACE  
 HYATTSVILLE, MD, 20782

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

2029

2029

2029

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Myron W. Hatton</b>				2. Date of Death Month Day Year <b>June 27, 1999</b>		3. Time of Death <b>9:50PM</b>									
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Rockville MD</b>		4c. County of Death <b>Montgomery</b>									
Funeral Director	5. Social Security Number <b>535-24-6456</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 15, 1922</b>									
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>									
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7503 Spring Lake Drive, #D2</b>		10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>United States</b>										
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>World War II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Floral Designer</b>		16b. Kind of Business/Industry <b>Florist</b>												
17. Father's Name (First, Middle, Last) <b>William Sumter Hatton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Leonberger</b>												
19a. Informant's Name/Relationship (Type, Print) <b>Margaret Hatton Haeringer/Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10134 Crestberry Place, Bethesda, Maryland 20817</b>												
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>July 1, 1999 Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>												
21. Signature of Funeral Service Licensee <b>David E. Perry, M00803</b>				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501</b>												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last             </td> <td>a. <b>Pancreatic Cancer</b> Due to (or as a consequence of):</td> <td>8 Months</td> </tr> <tr> <td>b. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):</td> <td>1 Week</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Pancreatic Cancer</b> Due to (or as a consequence of):	8 Months	b. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):	1 Week	c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Pancreatic Cancer</b> Due to (or as a consequence of):	8 Months														
	b. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):	1 Week														
	c. _____ Due to (or as a consequence of):															
	d. _____ Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Joseph M. Haggerty MD</b>		29c. License number <b>D32407</b>		29d. Date signed (Month, Day, Year) <b>June 28, 1999</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph M. Haggerty, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850</b>																
31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>		32. Registrar's Signature <b>Denise B. Sparks</b>														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) Marguerite T. Heher				2. Date of Death Month Day Year June 27, 1999				3. Time of Death 1:45 pm	
4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
5. Social Security Number 579-52-6875		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 15, 1907		9. Birthplace (State or Foreign Country) Massachusetts	
Usual Residence of Decedent									
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2201 Colston Drive				10f. Zip Code 20910		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Economics Teacher			16b. Kind of Business/Industry St. Anthony's H.S.		
17. Father's Name (First, Middle, Last) Patrick Shea				18. Mother's Name (First, Middle, Maiden Surname) Anne Claire Drumm					
19a. Informant's Name/Relationship (Type, Print) Ann E. Spigone/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5507 Monroe Street, Hyattsville, MD 20784					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		Date July 1 1999		20c. Location - City or Town, State Washington, DC			
21. Signature of Funeral Service Licensee <i>Eric S. Scurl</i>				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd.W, Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure weeks Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24e. Were an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>unidey</i>				29c. License number D 28920		29d. Date signed (Month, Day, Year) June 28, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surinder Singh 7319 A Hanover Parkway, Greenbelt, MD 20770									
31. Date filed (Month, Day, Year) JUN 30 1999		32. Registrar's Signature <i>B. Sparks</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22051

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BESSIE PAULINE HELLER</b>						2. Date of Death Month Day Year <b>June 28, 1999</b>		3. Time of Death <b>7:00 PM</b>						
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>						4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>						
Funeral Director	5. Social Security Number <b>213-13-7143</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 28, 1907</b>		9. Birthplace (State or Foreign Country) <b>South Africa</b>						
	Usual Residence of Decedent														
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number <b>6121 Montrose Road</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>South Africa</b>									
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>								
17. Father's Name (First, Middle, Last) <b>Morris Goldstein</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Goldstein</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Joshua Heller, Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 39114, Washington, D.C. 20016</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Adas Israel Congregation Cemetery</b>		Date <b>June 29, 1999</b>		20c. Location - City or Town, State <b>Washington, D.C.</b>							
21. Signature of Funeral Service Licensee <i>Reginald V. [Signature]</i>						22. Name and Address of Facility <b>TAKOMA FUNERAL HOME, INC. 254 CARROLL STREET, NW, WASHINGTON, DC 20012</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a. <b>CARDEOGENIC SHOCK</b> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <b>HOURS</b></td> </tr> <tr> <td>b. <b>ACUTE ANTERIOR WALL MI</b> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>CARDEOGENIC SHOCK</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>HOURS</b>	b. <b>ACUTE ANTERIOR WALL MI</b> Due to (or as a consequence of):	c. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>CARDEOGENIC SHOCK</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>HOURS</b>													
	b. <b>ACUTE ANTERIOR WALL MI</b> Due to (or as a consequence of):														
	c. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):														
	d.														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>AORTIC VALVE STENOSIS</b> <b>MITRAL REGURGITATION</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>R. Oatman</i>		29c. License number <b>MD40576</b>		29d. Date signed (Month, Day, Year) <b>June 28, 1999</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ramin OSKoui 3301 New Mexico Ave NW #202 WAS DC 20016</b>															
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature <i>[Signature]</i>													

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Heller, Bessie P. 7:00 PM  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.







99 22052

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22053

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nettie C. Henley

2. Date of Death

Month June 28, 1999 Year

3. Time of Death

1:48 PM

4a. Facility Name (If not institution, give street and number)

Frederick Health Care Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

215-03-6154

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Sept. 5, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Mount Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7817 Ridge Drive

10f. Zip Code

21771

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Sewing Factory

17. Father's Name (First, Middle, Last)

Oliver Granville Henley

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Cornelia Young

19a. Informant's Name/Relationship (Type, Print)

William D. Henley - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

#12 Park Avenue, Mount Airy, Maryland 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Pine Grove Cemetery

Date

7/1/99

20c. Location - City or Town, State

Mount Airy, Maryland

21. Signature of Funeral Service Licensee

Olin L. Molesworth

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home  
26401 Ridge Road, Damascus, Maryland 2087223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. aspiration pneumonia

Due to (or as a consequence of):

b. Parkinson's Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Deathfrom 10 days  
years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

R. Miller

29c. License number

026499

29d. Date signed (Month, Day, Year)

June 29, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ronald E. Miller, MD 4 Culwell Drive, Mt. Airy, Md. 21771

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Amended line 10a, 10b, 10c,  
10e, 10f, FCHD, KS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22056

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM HURWITZ				2. Date of Death Month June Day 21, Year 1999		3. Time of Death 7:02 P.M.			
	4a. Facility Name (If not Institution, give street and number) 12147 Pleasant Walk Road				4b. City, Town, or Location of Death Myersville		4c. County of Death Frederick			
Funeral Director	5. Social Security Number 214-28-5446		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 9, 1923		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State New York		10b. County Palm Beach		10c. City, Town or Location New York Boca Raton				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2000 Broadway				10f. Zip Code 10023 33487-1255		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Jeweler			16b. Kind of Business/Industry Jewelry		
	17. Father's Name (First, Middle, Last) Benjamin Hurwitz				18. Mother's Name (First, Middle, Maiden Surname) Rae Pushkin					
	19a. Informant's Name/Relationship (Type, Print) Marilyn Hurwitz - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Broadway, New York, New York 10023					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens		Date 6/23/99		20c. Location - City or Town, State Frederick, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Homes, P A 1621 Opossumtown Pike, Frederick, Maryland 21702					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Adenocarcinoma of lung</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <u>18 months</u>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D-13971		29d. Date signed (Month, Day, Year) 6/22/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 W. 9th St. Frederick MD 21701										
31. Date filed (Month, Day, Year) JUN 22 1999										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARVIN LESLIE HANN

2. Date of Death

Month Day Year  
June 28, 1999

3. Time of Death

11:30 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

213-24-9808

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 19, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Lewistown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6926 Fish Hatchery Road

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Fred. Co. School Board

17. Father's Name (First, Middle, Last)

James Leslie Hann

18. Mother's Name (First, Middle, Maiden Sumama)

Minerva Fraley

19a. Informant's Name/Relationship (Type, Print)

Shirley S. Hann (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6926 Fish Hatchery Rd., Lewistown, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resthaven Mem. Gardens

Date

7/1/99

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.  
615 EAST MAIN ST., THURMONT, MD 2178823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Hepatic Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Lung Cancer

Due to (or as a consequence of):

14 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 41866

29d. Date signed (Month, Day, Year)

JUNE 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanan Hudhud, MD 801 Toll House Avenue, Frederick, Maryland 21701

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

March 10, 1944

Dear Mr. [illegible]:

Enclosed for you are [illegible]

the [illegible] [illegible]

and [illegible] [illegible]

which [illegible] [illegible]

are [illegible] [illegible]

and [illegible] [illegible]

very [illegible] [illegible]

truly [illegible] [illegible]

Sincerely,  
[illegible]

[illegible signature]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22056

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mary. Hinchcliff</i>				2. Date of Death Month <i>June</i> Day <i>24</i> Year <i>1999</i>				3. Time of Death <i>12:59 P.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Deer's Head Center</i>				4b. City, Town, or Location of Death <i>Salisbury</i>				4c. County of Death <i>Wicomico</i>	
Funeral Director	5. Social Security Number <i>218-20-8563</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>72</i> Yrs.		8. Date of Birth Month <i>5</i> Day <i>15</i> Year <i>27</i>		9. Birthplace (State or Foreign Country) <i>MD</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>MD</i>		10b. County <i>Wicomico</i>		10c. City, Town or Location <i>Salisbury</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>318 Cedar Drive</i>				10f. Zip Code <i>21804</i>		10g. Citizen of What Country? <i>U.S.A</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i></i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Retail Sales</i>				16b. Kind of Business/Industry <i>Clothing</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Albert Rill Hopkins</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Rosette Insley</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Stanley Hinchcliff - Husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>318 Cedar Drive Salisbury, MD 21804</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Wicomico Mem. Park</i>		20c. Date <i>6/21</i>		20d. Location - City or Town, State <i>Salisbury, MD</i>			
	21. Signature of Funeral Service Licensee <i>Cornelius Messink</i>				22. Name and Address of Facility <i>Messink Funeral Home, P.O. Box 61 Baltimore, MD 21214</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Recurrent CVA with altered mental - 2 wks</i> Due to (or as a consequence of): <i>Stroke and dysphagia</i> <i>b. Severe Arteriosclerotic cardiovascular disease 9 yrs.</i> Due to (or as a consequence of): <i>Recurrent CHF.</i> Due to (or as a consequence of): <i></i>								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ESRD on hemodialysis</i> <i>COPD with MRSA in sputum</i>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>M. Shrestha MD</i>		29c. License number <i>D16278</i>		29d. Date signed (Month, Day, Year) <i>6/24/99</i>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>M. SHRESTHA, MD P.O. Box 2018, SALISBURY, MD 21802</i>									
	31. Date filed (Month, Day, Year) <i>JUN 25 1999</i>		32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

12/14/21

12/14/21

12/14/21

12/14/21

12/14/21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

994

99 22057

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ELDER INSKEEP

2. Date of Death

Month Day Year  
June 27, 1999

3. Time of Death

9:42 AM

4a. Facility Name (If not institution, give street and number)

Northampton Manor Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

234-38-7765

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 23, 1923

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1421 Taney Avenue Apartment 224

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Advertising

17. Father's Name (First, Middle, Last)

J. Machir Inskeep

18. Mother's Name (First, Middle, Maiden Surname)

Edna McNeill

19a. Informant's Name/Relationship (Type, Print)

Betty J. Alexander, niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5957 Picnic Woods Road Jefferson, Maryland 21755

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hagerstown Crematory

Date

6/28/99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.  
1621 Opossumtown Pike Frederick, Maryland 21702

23a. (Print). Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL VASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 WKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Donelson MD

29c. License number

J 21936

29d. Date signed (Month, Day, Year)

6/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DONELSON, MD 170 THOMAS JOHNSON DR., SUITE 100, FREDERICK, MD 21702

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22058

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ethel W. Jacobs</b>				2. Date of Death Month Day Year <b>June 30, 1999</b>		3. Time of Death <b>3:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Wilson Health Care Center at Asbury Village</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>219-36-7789</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>104</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 22, 1894</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>211 Russell Avenue, #215</b>		10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Montgomery County Public Schools</b>			
	17. Father's Name (First, Middle, Last) <b>Charles E. Waters</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maude A. Gingell</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Charles T. Jacobs, Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>396 Russell Avenue, Gaithersburg, MD 20877</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Oak Cemetery</b>		20c. Location - City or Town, State <b>Gaithersburg, MD</b>		20d. Date <b>7-3-99</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Cerebral Vascular Accident</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Coronary Artery Disease</b> <b>Breast Cancer</b>							
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>Priscilla Callahan-Lyon MD</b>		29c. License number <b>041794</b>		29d. Date signed (Month, Day, Year) <b>June 30, 1999</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Priscilla Callahan-Lyon, M.D., 911 Russell Avenue, Gaithersburg, MD 20879</b>							
	31. Date filed (Month, Day, Year) <b>JUL 02 1999</b>		32. Registrar's Signature <i>[Signature]</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22059

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Waverlyn Jenifer

2. Date of Death

June 26, 1999

3. Time of Death

12:30 AM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

578-20-4799

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 1, 1907

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2731 Yeomans Lantern Court

10f. Zip Code

21402

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

D.C. Government

17. Father's Name (First, Middle, Last)

Waverly Green

18. Mother's Name (First, Middle, Maiden Surname)

Mary Wade

19a. Informant's Name/Relationship (Type, Print)

Joseph E. Jenifer, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1456 Chesapeake Avenue, Annapolis, Maryland 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

6/30/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service, Inc.  
7400 Georgia Ave. N.W., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

1 Day

Due to (or as a consequence of):

b. Cardiogenic Shock

12 hours

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis M. Hall, M.D. 1204 West St. Annapolis Md 21401

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

Dennis M. Hall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12



SW



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22060

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lorraine T. Johnson

2. Date of Death

Month Day Year  
June 27, 1999

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

1000 Broadmore Cir

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-30-8713

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 14, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1000 Broadmore Cir

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

DC Government

17. Father's Name (First, Middle, Last)

Thomas E. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Edna Fogle

19a. Informant's Name/Relationship (Type, Print)

Alice C. Johnson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1000 Broadmore Cir, Silver Spring, MD 20904

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Crematory

Date

Jun 28

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

▶ *Alana J. Daniels*

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Ave, Silver Spring, MD 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Congestive Heart Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 years

b.

Myocardial Infarction

Due to (or as a consequence of):

10 years

c.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

▶ *Richard Weinstein, MD*

29c. License number

D42777

29d. Date signed (Month, Day, Year)

June 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Weinstein 18111 Prince Philip Drive Olney, Maryland 20832

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

▶ *Beverly B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22061

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Charles Ervin Kanode, Jr.</b>		2. Date of Death Month <b>June</b> Day <b>25</b> , Year <b>1999</b>		3. Time of Death <b>5:10 pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>216-14-6484</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.	
8. Date of Birth Month <b>March</b> Day <b>12</b> , Year <b>1922</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inade City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>325 Catoclin Avenue</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Nov 1943 - Mar 1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Heavy Equipment Mechanic</b>		16b. Kind of Business/Industry <b>Road builders</b>	
17. Father's Name (First, Middle, Last) <b>Charles E. Kanode, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Faye V. Berg</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Gary Wayne Kanode/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9311 White Rock Ave., Frederick, Md. 21702</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Memorial Gardens</b>		20c. Location - City or Town, State <b>Frederick, Md.</b>	
21. Signature of Funeral Service Licensee <b>Richard C.C. Basford</b>		22. Name and Address of Facility <b>Keeney &amp; Basford Funeral Home 106 East Church Street, Frederick, Md. 21701</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Aortic dissection with cardiac tamponade 5 days</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Prostate Carcinoma with hydroureters &amp; acute renal insufficiency dx 6/21/88, Hypertension, Carcinoid tumor RLL 6/86</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>6/21/88</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>James S. Gristen MD</b>		29c. License number <b>D21944</b>		29d. Date signed (Month, Day, Year) <b>6/26/89</b>	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>James S. Gristen MD 300 W 9th St. Frederick, Md. 21701</b>					
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22062

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD LAWRENCE KOSKI

2. Date of Death

Month Day Year  
JUNE 29 1999

3. Time of Death

5:15PM

4a. Facility Name (If not institution, give street and number)

6421 PALMERS MILL ROAD

4b. City, Town, or Location of Death

HURLOCK

4c. County of Death

DORCHESTER

Funeral  
Director

5. Social Security Number

218-58-1176

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 7, 1950

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

DORCHESTER

10c. City, Town or Location

HURLOCK

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6421 PALMERS MILL ROAD

10f. Zip Code

21643

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No 1977-  
If Yes, Give Year or Dates: 1992

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Trucking and Warehousing

17. Father's Name (First, Middle, Last)

FRANCIS NAPOLEAN KOSKI

18. Mother's Name (First, Middle, Maiden Surname)

BONNIE L. TODD

19a. Informant's Name/Relationship (Type, Print)

KATHERINE O. KOSKI/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6421 PALMERS MILL ROAD, HURLOCK, MD 21643

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD VET. CEM. EASTERSHORE

Date

7/2/99

20c. Location - City or Town, State

BEULAH, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Zeller Funeral Home, P. O. Box 207,  
106 Main Street, East New Market, MD 21631

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Carcinoma

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

4 1/2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending investigation  
☐ Accident 6 ☐ Could not be determined  
☐ Suicide  
☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D39887

29d. Date signed (Month, Day, Year)

7/1/99

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

David Smith, M.D., 29466 Pintail Drive, Easton, MD 21601

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

*[Signature]*

Anne Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22063

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Shigeyoshi Seichi Kariya</b>				2. Date of Death Month Day Year <b>June 25, 1999</b>		3. Time of Death <b>12:35 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>559-28-9672</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 3, 1915</b>	
9. Birthplace (State or Foreign Country) <b>Japan</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>North Bethesda</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>10938 Bloomingdale Drive</b>		10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Executive</b>		16b. Kind of Business/Industry <b>Import</b>			
17. Father's Name (First, Middle, Last) <b>Risaburo Kariya</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Masa Hayakawa</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Kiyo Jean Kariya/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20852</b> <b>10938 Bloomingdale Drive, North Bethesda, Maryland</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>June 27, 1999</b> <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Michael E. Higgins</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.</b> <b>7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Pneumonia</b> Due to (or as a consequence of): b. <b>Dysphagia</b> Due to (or as a consequence of): c. <b>Aspiration</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>Days</b> <b>months</b> <b>months</b>			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Bilateral Subdural Hematomas</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Robert G. Fink</b>		29c. License number <b>043414</b>		29d. Date signed (Month, Day, Year) <b>June 25, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert G. Fink 10301 Lockwood Drive, Silver Spring, Maryland</b>							
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature <b>Shirley B. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

26

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22064

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Theodore John Kaznocha</b>				2. Date of Death Month <b>June</b> Day <b>23</b> Year <b>1999</b>		3. Time of Death <b>1:00AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care-Fernwood</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>055-05-9559</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 26, 1920</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>n/a</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Washington, DC</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2301 E Street #A1109</b>				10f. Zip Code <b>20037</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1940-</b> If Yes, Give Year or Dates: <b>1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Officer</b>		16b. Kind of Business/Industry <b>U.S Dept. of State</b>	
	17. Father's Name (First, Middle, Last) <b>Andrew Kaznocha</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maryanna Krakowska</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Olga C. Kaznocha</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2301 E Street NW #A1109 Washington, DC 20037</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Crematory</b>		Date <b>6/28/99</b>	20c. Location - City or Town, State <b>Falls Church, VA</b>		
	21. Signature of Funeral Service Licensee <b>Thomas E. Honnaker</b>				22. Name and Address of Facility <b>Joseph Gawler's Sons INC, 5130 Wisconsin AVE. NW, Washington, DC 20016</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. TUBERCULOSIS</b> Due to (or as a consequence of): <b>b. CHF.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>H 0051280</b>		29d. Date signed (Month, Day, Year) <b>6-24-99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANUSH DAVANLDO 13219 EXECUTIVE PARK TERRACE GERMANTOWN MD 20874.</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22065

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>KROCH KENT</u>				2. Date of Death Month Day Year <u>JUNE 22, 1999</u>		3. Time of Death <u>9:14 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>SOUTHERN MARYLAND HOSPITAL</u>				4b. City, Town, or Location of Death <u>CLINTON</u>		4c. County of Death <u>P G</u>	
Funeral Director	5. Social Security Number <u>577-62-8093</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>70</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>12-05-28</u>	
	9. Birthplace (State or Foreign Country) <u>CAMBODIA</u>		10e. State <u>MD</u>		10b. County <u>P G</u>		10c. City, Town or Location <u>CLINTON</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10f. Street and Number <u>7904 GODFREY CT</u>		10g. Zip Code <u>20735</u>		10h. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>ASIAN</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>BROADCASTER</u>		16b. Kind of Business/Industry <u>RADIO</u>		17. Father's Name (First, Middle, Last) <u>KEN KHOENG</u>		
18. Mother's Name (First, Middle, Maiden Surname) <u>CHEAL THE</u>		19a. Informant's Name/Relationship (Type, Print) <u>SAVIN KENT</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7904 GODFREY CT CLINTON MD 20735</u>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <u>NATIONAL MEMORIAL PARK</u>		20c. Location - City or Town, State <u>6/26/99 FALLS CHURCH, VA</u>		21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>NATIONAL FUNERAL HOME</u> <u>7482 LEE HIGHWAY FALLS CHURCH, VA 22042</u>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>CARDIO RESPIRATORY ARREST</u> Due to (or as a consequence of): b. <u>VENTRICULAR TACHYCARDIA/FIBRILLATION</u> Due to (or as a consequence of): c. <u>PULMONARY HEMORRHAGE POST BIOPSY</u> Due to (or as a consequence of): d. <u>COMMUNITY ACQUIRED PNEUMONIA</u>		Approximate Interval Between Onset and Death <u>&lt; 1 hr</u> <u>&lt; 1 hr</u> <u>&lt; 1 hr</u> <u>&lt; 1 wk</u>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CORONARY ARTERY DISEASE, POST BYPASS</u> <u>CEREBROVASCULAR ACCIDENTS, VASCULAR DISEASE</u> <u>HYPERTENSION, HYPERLIPIDEMIA, EX-SMOKER</u>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <u>[Signature] L. Srinivasan, MD</u>		29c. License number <u>D 46345</u>		29d. Date signed (Month, Day, Year) <u>JUNE, 23, 1999</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>BOBALAKRISHNAN SRINIVASAN</u> <u>CLINTON, MD 20735</u>		
31. Date filed (Month, Day, Year) <u>JUN 28 1999</u>		32. Registrar's Signature <u>[Signature]</u>		33. Registrar's Title <u>[Signature]</u>		34. Registrar's Name <u>[Signature]</u>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



DIVISION OF VITAL RECORDS, P.O. BOX 68766 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR										STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE										CERTIFICATE OF DEATH										REG. NO.																																																																					
1. DECEDENT'S NAME (First, Middle, Last) RICHARD H. KING																				2. DATE OF DEATH MONTH DAY YEAR JUNE 29 1999										3. TIME OF DEATH 4:45 AM																																																																					
4. SOCIAL SECURITY NUMBER 213-01-1863										5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F					6. AGE (In yrs. last birthday) 84 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.					7. DATE OF BIRTH (Month, Day, Year) May 27, 1915										8. BIRTHPLACE (State or Foreign Country) Maryland																																																											
9a. FACILITY NAME (If not institution, give street and number) 10619 Ordway Drive																				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring																				9c. COUNTY OF DEATH Montgomery																																																											
RESIDENCE OF DECEDENT																				10a. STATE Maryland																				10b. COUNTY Montgomery																				10c. CITY, TOWN OR LOCATION Silver Spring																				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO																			
10e. STREET AND NUMBER 10619 Ordway Drive																				10f. ZIP CODE 20901																				10g. CITIZEN OF WHAT COUNTRY? USA																																																											
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II										13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:										14. RACE — American Indian, Black, White, etc. Specify: White																																																																					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1										16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Branch Manager										16b. KIND OF BUSINESS/INDUSTRY Optical Company																																																																															
17. FATHER'S NAME (First, Middle, Last) Roy King																				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jeannette King																																																																															
19a. INFORMANT'S NAME (Type/Print) Evelyn Bozinko (daughter)																				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13908 Shippers Lane Rockville, Maryland 20853																																																																															
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 7/2/99 Silver Spring, Maryland										20c. LOCATION — City or Town, State																																																																															
21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. Kevin Gutowski																				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD																																																																															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. SMOKING DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.																				Approximate Interval Between Onset and Death 4 YRS 4 YRS																																																																															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO																																																																					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>																																																																																																			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																																																																									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										28a. DATE OF INJURY (Month, Day, Year)										28b. TIME OF INJURY M					28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					28d. DESCRIBE HOW INJURY OCCURRED																																																																					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)																				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)																																																																															
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				29b. SIGNATURE AND TITLE OF CERTIFIER Steven T. Kariya MD																				29c. LICENSE NUMBER 136252										29d. DATE SIGNED (Month, Day, Year) JUNE 30 1999																																																	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN T. KARIYA, MD, 11501 GEORGIA AVE #515, WHEATON MD 20902																																																																																																			
31. DATE FILED (Month, Day, Year) JUL 02 1999																				32. REGISTRAR'S SIGNATURE B. Sparks																																																																															



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22067

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John E. Kuffner

2. Date of Death

Month Day Year  
June 26, 1999

3. Time of Death

7:45AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Aspenwood Senior Living

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

168-05-1284

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 26, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14400 Homecrest Road, #250

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

1943-

1973

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Army Ordinance Officer

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Erwin L. Kuffner

18. Mother's Name (First, Middle, Maiden Surname)

Hilda G. Scheffter

19a. Informant's Name/Relationship (Type, Print)

Stephen J. Kuffner/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7306 Ferncliffe Drive, Huntsville, Alabama 35802

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

June 30, 1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

MO1126

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

Assisted Living

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

0101058086 VA

29d. Date signed (Month, Day, Year)

June 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John H. Smith, Jr., M.D. National Naval Medical Center, Bethesda, Maryland 20889

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22068

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Warren Talmadge LENHART</b>				2. Date of Death Month Day Year <b>June 30, 1999</b>		3. Time of Death <b>5:15 pm</b>	
4a. Facility Name (If not institution, give street and number) <b>113 Kline Blvd</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>234-62-7638</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jun 14, 1921</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Frederick</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No		
10e. Street and Number <b>113 Kline Blvd</b>			10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No <b>1940-</b> If Yes, Give Year or Dates: <b>1961</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Military/Government</b>		16b. Kind of Business/Industry <b>Pilot/Public Relations</b>			
17. Father's Name (First, Middle, Last) <b>Clemon Henry LENHART</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Naomi Ruth STRINE</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Ione Racho Lenhart/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>113 Kline Blvd, Frederick, Maryland 21701</b>			
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt Olivet Cemetery Jul 03, 1999</b>		Date <b>Jul 03, 1999</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Keeney &amp; Basford P.A. Funeral Home</i> <b>MO0706</b>		22. Name and Address of Facility <b>Keeney &amp; Basford P.A. Funeral Home</b> <b>106 East Church St, Frederick, Maryland 21701</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Alzheimer's disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>10 years</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>10 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pacemaker</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown	
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No					
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1</b> Yes <b>2</b> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Ali J. Afrookteh</i>		29c. License number <b>D35183</b>		29d. Date signed (Month, Day, Year) <b>July 01, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ali J. Afrookteh, M.D., 300 West Ninth Street, Frederick, Maryland 21701</b>							
31. Date filed (Month, Day, Year) <b>JUL 02 1999</b>		32. Registrar's Signature <i>B. Sparks</i>					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22069

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Flossie Layfield</b>		2. Date of Death Month Day Year <b>June 24, 1999</b>		3. Time of Death <b>4:45 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center: Genesis ElderCare</b>		4b. City, Town, or Location of Death <b>Salisbury, MD</b>		4c. County of Death <b>Wicomico</b>
Funeral Director	5. Social Security Number <b>214-10-6557</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days <b>2 1</b>	If Under 24 Hrs. Hours Min. <b>2 1</b>
	8. Date of Birth (Month, Day, Year) <b>SEPT. 12, 1908</b>		9. Birthplace (State or Foreign Country) <b>DELAWARE</b>		
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>SALISBURY</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>200 CIVIC AVE.</b>			10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SEAMSTRESS</b>		16b. Kind of Business/Industry <b>SHIRT FACTORY</b>	
17. Father's Name (First, Middle, Last) <b>JACOB C. SAVAGE</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>HANNAH TIMMONS</b>		
19a. Informant's Name/Relationship (Type, Print) <b>CHARLES R. DASHIELL - PER. REP.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>126 E. MAIN ST. SALISBURY, MD 21801</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SPRINGHILL MEMORY GARDENS</b>		20c. Location - City or Town, State <b>HEBRON, MARYLAND</b>	
21. Signature of Funeral Service Licensee <b>B. Reist</b>		22. Name and Address of Facility <b>BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. 21804 SALISBURY, MARYLAND</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b>					
Due to (or as a consequence of): <b>Advanced Dementia</b>					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Approximate Interval Between Onset and Death <b>1 Day</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b> <b>DM</b> <b>CAO</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D 39813</b>		29d. Date signed (Month, Day, Year) <b>6/24/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804</b>					
31. Date filed (Month, Day, Year) <b>JUN 25 1999</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22070

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Aldine Niekirk McNamee

2. Date of Death

Month  
JuneDay  
23Year  
1999

3. Time of Death

0840

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington Co.

5. Social Security Number

219-20-1579

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 1, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington Co.

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17904 Pin Oak Road

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1951-

1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Food Manufacturer

17. Father's Name (First, Middle, Last)

Charles William McNamee

18. Mother's Name (First, Middle, Maiden Surname)

Edith K. Niekirk

19a. Informant's Name/Relationship (Type, Print)

Madeline P. McNamee, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17904 Pin Oak Road, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Lawn Memorial Pk. June 26

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Douglas A. Fiery Funeral Home

22. Name and Address of Facility

1331 Eastern Blvd.N., Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 day

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

George C. Newman, Jr., Ph.D., MD D17591

29c. License number

29d. Date signed (Month, Day, Year)

6/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George C. Newman, Jr., 11110 Medical Campus Road, Hagerstown, Maryland 21742

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 25 1999

32. Registrar's Signature

N. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22071

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) Gertrude Anastasia Mackrell				2. Date of Death Month Day Year June 26, 1999		3. Time of Death 1557	
4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington County	
5. Social Security Number 209-18-1420		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 13, 1926	
9. Birthplace (State or Foreign Country) Pennsylvania							
Usual Residence of Decedent							
10a. State Maryland		10b. County Washington Co.		10c. City, Town or Location Hagerstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 369 Antietam Drive				10f. Zip Code 21742		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Hospital	
17. Father's Name (First, Middle, Last) John McCormick				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Marion			
19a. Informant's Name/Relationship (Type, Print) Paul Murray Mackrell, Sr./Hus.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 369 Antietam Drive, Hagerstown, Maryland 21742			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		Date June 30		20c. Location - City or Town, State Hagerstown, Maryland	
21. Signature of Funeral Service Licensee Kelley A. Zimmerman				22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR FIBRILLATION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. DIABETES MELLITUS, TYPE 2 AND Due to (or as a consequence of): d. HYPERTENSION Approximate Interval Between Onset and Death SECONDS DECADE DECADE							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OBESITY							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature of Certifier Family Physician				29c. License number D 7067		29d. Date signed (Month/Day, Year) 6/27/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN METER, MD 747 NORTHERN AVE. HAGERSTOWN, MD							
31. Date filed (Month, Day, Year) JUN 29 1999				32. Registrar's Signature B. Spauls			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar

Mackrell, Gertrude Anastasia

1. The first part of the paper  
is devoted to a general  
discussion of the problem.

2. The second part of the paper  
is devoted to a detailed  
analysis of the problem.

3. The third part of the paper  
is devoted to a detailed  
analysis of the problem.

4. The fourth part of the paper  
is devoted to a detailed  
analysis of the problem.

5. The fifth part of the paper  
is devoted to a detailed  
analysis of the problem.

6. The sixth part of the paper  
is devoted to a detailed  
analysis of the problem.

7. The seventh part of the paper  
is devoted to a detailed  
analysis of the problem.

8. The eighth part of the paper  
is devoted to a detailed  
analysis of the problem.

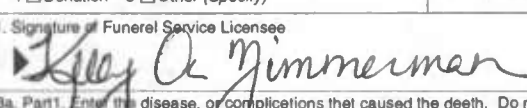

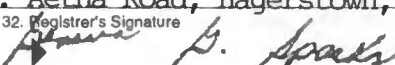


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KITTY ELINOR MOXLEY</b>				2. Date of Death Month Day Year <b>June 25, 1999</b>		3. Time of Death <b>11:10 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Western Maryland Hospital Center</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington County</b>	
Funeral Director	5. Social Security Number <b>220-30-9209</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 12, 1926</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>Western Maryland Hospital Center</b>				10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Rhumus Lee Moxley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Kitty Louise Williams</b>				
19a. Informant's Name/Relationship (Type, Print) <b>William Jeffery Moxley, Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4318 Varnum Place N.E., Washington, D.C. 20017</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>			Date <b>June 28</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Douglas A. Fiery Funeral Home</b> <b>1331 Eastern Blvd. N., Hagerstown, Maryland 21742</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. End stage renal failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>&gt;1 year</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia, atrial flutter</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 			29c. License number <b>D36655</b>		29d. Date signed (Month, Day, Year) <b>June 25, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Samuel Chan, 1185 Mt. Aetna Road, Hagerstown, Maryland 21740</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22073

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William F. Magers

2. Date of Death

June 28, 1999

3. Time of Death

5:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Randolph Hill Nursing Home

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

5. Social Security Number

577-10-8115

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Dec. 26, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

116 Whitmoor Terrace

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John Henry Magers

18. Mother's Name (First, Middle, Maiden Surname)

Lula V. Mills

19a. Informant's Name/Relationship (Type, Print)

Margaret Magers (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 Whitmoor Terrace Silver Spring, Maryland 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

7/1/99

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Myocardopathy

Due to (or as a consequence of):

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Heart Disease; Cerebral Infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Martin C. Shargel, M.D.

29c. License number

D 08944

29d. Date signed (Month, Day, Year)

June 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin C. Shargel, M.D. 3720 Farragut Avenue Kensington, Maryland 20895-2110

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22074

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rakhil Mandelgeym				2. Date of Death Month Day Year June 25, 1999				3. Time of Death 12:49 AM.	
	4a. Facility Name (If not Institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville, MD				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 220-02-6864		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) July 14, 14		9. Birthplace (State or Foreign Country) Ukraine	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 101 Oden Hal Ave. #703				10f. Zip Code 20877		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry Education	
	17. Father's Name (First, Middle, Last) Sruei Mandelgeym				18. Mother's Name (First, Middle, Maiden Surname) Unknown					
	19a. Informant's Name/Relationship (Type, Print) Alexander Naygauz/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Cole Brook Ct. Potomac, MD. 20854					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial		Date 6/27		20c. Location - City or Town, State Olney, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Takoma Funeral Home. 254 Carroll St. NW. Washington, DC. 20012					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. PULMONARY EMBOLUS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier  29c. License number 047235 29d. Date signed (Month, Day, Year) 6/25/99										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel D. Lahr, MD. 9707 Medical Center Dr. Rockville, MD. 20850										
31. Date filed (Month, Day, Year) JUN 29 1999 32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

CHICAGO, ILLINOIS

RECEIVED

APRIL 10 1954

FROM

DR. ROBERT H. WOODWARD

TO

DR. ROBERT H. WOODWARD

CHICAGO, ILLINOIS

RECEIVED

APRIL 10 1954

FROM

DR. ROBERT H. WOODWARD

TO

DR. ROBERT H. WOODWARD

CHICAGO, ILLINOIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22075

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RONA DIANE MAJOWER				2. Date of Death Month Day Year JUNE 27, 1999		3. Time of Death 8:14 PM	
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 212-68-4236	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 1, 1964		9. Birthplace (State or Foreign) WASHINGTON, DC
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 11736 LOVEJOY STREET				10f. Zip Code 20902		10g. Citizen of What Country? UNITED STATES		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DENTAL ASSISTANT			16b. Kind of Business/Industry DENTISTRY	
17. Father's Name (First, Middle, Last) HERBERT MAJOWER				18. Mother's Name (First, Middle, Maiden Surname) JOAN GIMBLE				
19a. Informant's Name/Relationship (Type, Print) HERBERT MAJOWER (FATHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11736 LOVEJOY STREET - SILVER SPRING, MD. 20902				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GDNS.		Date 6/29/99		20c. Location - City or Town, State OLNEY, MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS - HEPATIC FAILURE Due to (or as a consequence of): b. SHORT BOWEL SYNDROME Due to (or as a consequence of): c. EHLERS-DANLOS SYNDROME Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 WEEK 4 YEARS 34 YEARS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D02490		29d. Date signed (Month, Day, Year) JUNE 28, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. COHEN, MD - 2102 MEDICAL PARK DRIVE - SILVER SPRING, MD. 20902								
31. Date filed (Month, Day, Year) JUN 30 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3







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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22076

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NORMAN

MARLOWE

2. Date of Death

JUNE 28, 1999

3. Time of Death

9:10 AM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

578-14-7452

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

SEPT. 23, 1915

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6904 NEVIS ROAD

10f. Zip Code

20817

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No

If Yes, Give Year or Dates: MARINES

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PRESIDENT

16b. Kind of Business/Industry

PARKLAWN CEMETERY

17. Father's Name (First, Middle, Last)

ROBERT MARLOWE

18. Mother's Name (First, Middle, Maiden Surname)

CELIA SNAPPER

19a. Informant's Name/Relationship (Type, Print)

DR. WENDY MARLOWE (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6205 RAVENNA AVENUE, NE-SEATTLE, WASHINGTON 98115

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NATIONAL FUNERAL HOME

Date

6/29/99

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILL PIKE-ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CANCER pulmonary metast

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

VENTILATION DEPENDENCE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Dr. R. Kato MD

00052774

6/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEO C. ROTELLO MD, SUBURBAN HOSPITAL, BETHESDA MD

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #7,8, 6/30/99, JW, Montg. Cty.

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

JOHN A. MARTIN

2. Date of Death  
Month Day Year

JUNE 24, 1999

3. Time of Death

6:00PM

4a. Facility Name (If not institution, give street and number)

ROCKVILLE NURSING HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

230.15.5898

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 ~~85~~ Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 1915

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND MONTGOMERY

10b. County

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5403 GOLDSBORO ROAD

10f. Zip Code

20817

10g. Citizen of What Country?

usa

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REALTOR

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

ANDREW BRAXTON MARTIN

18. Mother's Name (First, Middle, Maiden Surname)

REVA CARDWELL

19a. Informant's Name/Relationship (Type, Print)

KENNETH W. THOMPSON/NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5403 GOLDSBORO ROAD, BETHESDA, MARYLAND 20817

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EARLYS CHAPEL CEMETERY

Date

6.27.99

20c. Location - City or Town, State

CONCORD, VIRGINIA

21. Signature of Funeral Service Licensee

Donald S. Stattemyer

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Elliot R. Goldstein

29c. License number

D03581

29d. Date signed (Month, Day, Year)

06.25.1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliot R. Goldstein, md, fccp, facp

5480 Wisconsin Avenue, LL5, CHEVY CHASE, MD 20815

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22078

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MORGAN ZACHARIAH MAYBERRY</b>				2. Date of Death Month: <b>June</b> Day: <b>28</b> Year: <b>1999</b>		3. Time of Death <b>0124</b>		
	4a. Facility Name (If not institution, give street and number) <b>10102 GEORGIA AVE</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>413-39-0750</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>19</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 4 1980</b>		
	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Usual Residence of Decedent				10e. Street and Number <b>10102 Georgia Ave.</b>		10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Attendant</b>		16b. Kind of Business/Industry <b>Building Supply</b>			
17. Father's Name (First, Middle, Last) <b>James E. Mayberry</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Robyn Nestler</b>					
19a. Informant's Name/Relationship (Type, Print) <b>James E. Mayberry (father)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1905 Ladd Street Wheaton, Md. 20902</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory</b>		Date <b>6/30/99</b>		20c. Location - City or Town, State <b>Brentwood, Md.</b>			
21. Signature of Funeral Service Licensee <i>Louis L. Grant</i>				22. Name and Address of Facility <b>Hines-Rinaldi F. H.</b> <b>11800 New Hampshire Ave. Silver Spring, Md. 20904</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SHOTGUN WOUND TO HEAD</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>June 28, 1999</b>		28b. Time of Injury <b>0124 M</b>	
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SELF-INFLICTED SHOTGUN WOUND TO HEAD</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>10102 GEORGIA AVE SILVER SPRING, MD</b>	
29a. Certifier (Check only) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>M.O. (OMB)</i>						29c. License number <b>015236</b>	
		29d. Date signed (Month, Day, Year) <b>JUNE 28, 1999</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CARL MARCOS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>									
31. Date filed (Month, Day, Year) <b>JUL 02 1999</b>		32. Registrar's Signature <i>Barbara B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

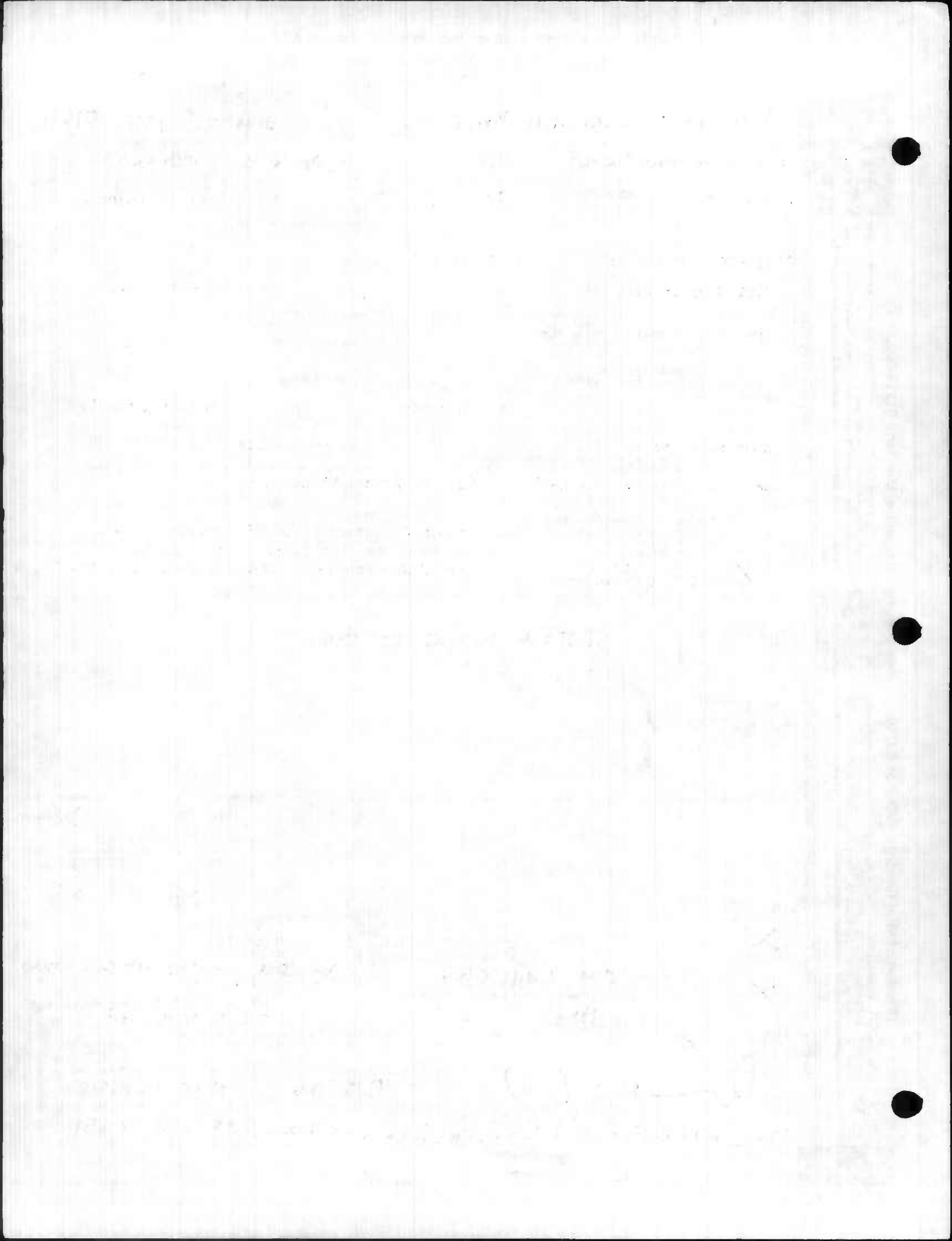
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22079

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY L. McCORMICK</b>				2. Date of Death Month Day Year <b>JUNE 25, 1999</b>		3. Time of Death <b>11:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>212-12-7796</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 5, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>WASH. D.C.</b>		10a. State <b>MD.</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>LANHAM</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5612 LANHAM STATION RD.</b>		10f. Zip Code <b>20706</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FIREMAN</b>		16b. Kind of Business/Industry <b>FIRE DEP'T.</b>				
17. Father's Name (First, Middle, Last) <b>HARRY L. McCORMICK SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LILLIAN PRESTON</b>		19a. Informant's Name/Relationship (Type, Print) <b>SHARON JOHNSON/DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		20c. Location - City or Town, State <b>7/1/99 RIVERDALE, MD.</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Premia</b> Due to (or as a consequence of): <b>b. sepsis</b> Due to (or as a consequence of): <b>c. Acute Renal Failure</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>days</b> <b>days</b>		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>		
29a. Certifier Check only one: <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D41978</b>		29d. Date signed (Month, Day, Year) <b>6-27-99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>N. TAVAKOLI PCH Cherry MD 20785</b>		31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



1. The first part of the report  
describes the general situation  
of the country and the  
state of the economy.  
It also mentions the  
main problems which  
the government is  
facing at present.  
The second part of the  
report deals with the  
financial situation of the  
country and the  
state of the public  
finances. It also  
mentions the main  
problems which the  
government is facing  
at present.

The third part of the  
report deals with the  
social situation of the  
country and the  
state of the public  
services. It also  
mentions the main  
problems which the  
government is facing  
at present. The fourth  
part of the report  
deals with the  
cultural situation of  
the country and the  
state of the public  
cultural institutions.  
It also mentions the  
main problems which  
the government is  
facing at present.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22080

Amend #26, 6/29/99, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Etta Jewel Merritt</b>				2. Date of Death Month Day Year <b>June 27, 1999</b>		3. Time of Death <b>12:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1515 Jasper Street</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>232-40-3046</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sep. 24, 1929</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>West Virginia</b>		10b. County <b>Kanawha</b>		10c. City, Town or Location <b>Belle</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>309 W 24th Street</b>		10f. Zip Code <b>25015</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Office Manager</b>		16b. Kind of Business/Industry <b>Trucking Company</b>			
	17. Father's Name (First, Middle, Last) <b>Harry Bunion Hawks</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Blanch Chatfield</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Jack M. Boyle, Jr. (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1515 Jasper Street Silver Spring, Maryland 20901</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Tyler Mt. Memory Gardens</b>		20c. Location - City or Town, State <b>West Virginia</b>		20d. Date <b>6/30/99</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>LUNG CANCER</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>son's residence</b>			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number <b>D29675</b>		29d. Date signed (Month, Day, Year) <b>June 28, 1999</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert J. Bucci MD 9707 MONROE CENTER DR ROCKVILLE MD</b>				31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>			
	32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22001

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dennison L. Mitchell</b>				2. Date of Death Month Day Year <b>June 24, 1999</b>		3. Time of Death <b>9:20AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3705 Woodbine St.</b>				4b. City, Town, or Location of Death <b>Chevy Chase</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>578-01-9494</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 14 1908</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>Md.</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3705 Woodbine Street</b>		10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+) 5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Certified Public Accountant</b>		16b. Kind of Business/Industry <b>Accounting</b>				
17. Father's Name (First, Middle, Last) <b>James Rossius Mitchell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sallie Jernigan</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Vivien E. Mitchell (spouse)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3705 Woodbine St., Chevy Chase, Md. 20815</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rock Creek Cemetery</b>		Date <b>6/28/99</b>		20c. Location - City or Town, State <b>Washington, D.C.</b>		
21. Signature of Funeral Service Licensee <b>Thomas E. Hennelaker</b>				22. Name and Address of Facility <b>Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016</b>				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>1 week</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Cerebrovascular Accident</b> Due to (or as a consequence of):				Years		
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Palberius</b>		29c. License number <b>D-31319</b>		29d. Date signed (Month, Day, Year) <b>June 24, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Loreto S. Albiol MD., 8218 Wisconsin Ave. #103, Bethesda, MD 20814</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature <b>Bruce B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 1 of 1

10/10/2010

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22082

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEANETTE WILLS MOODY

2. Date of Death

Month Day Year  
JUNE 28 1999

3. Time of Death

6:05 AM

4a. Facility Name (If not institution, give street and number)

9509 CAROLINE AVENUE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

234-28-0921

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 19, 1921

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9509 Caroline Avenue

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Montgomery  
Housing Commission

17. Father's Name (First, Middle, Last)

Elliott Wills

18. Mother's Name (First, Middle, Maiden Surname)

Nina

19a. Informant's Name/Relationship (Type, Print)

Patterson Moody / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9509 Caroline Avenue, Silver Spring, MD 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Roanoke Salem Baptist Ch.

Date

July 2 1999

20c. Location - City or Town, State

Garysburg, N.C.

21. Signature of Funeral Service Licensee

Ken Skile

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd. W, Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

mo. (OMB)

29c. License number

D15236

29d. Date signed (Month, Day, Year)

JUNE 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL I. MARGOLIS, MD, 1125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

Beverly B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22083

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine Eliza Myers</b>						2. Date of Death Month Day Year <b>June 27, 1999</b>		3. Time of Death <b>9:50 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>818 Gregorio Drive</b>						4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>220-92-7541</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 8, 1924</b>		9. Birthplace (State or Foreign Country) <b>Jamaica</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>818 Gregorio Drive</b>						10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>Jamaica</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Child Care Provider</b>		16b. Kind of Business/Industry <b>Self-Employed</b>			
17. Father's Name (First, Middle, Last) <b>Cyeril Myers</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Cinderella Hemmings</b>					
19a. Informant's Name/Relationship (Type, Print) <b>George A. Dawkins (son)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>818 Gregorio Drive Silver Spring, Maryland 20901</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		Date <b>7/3/99</b>		20c. Location - City or Town, State <b>Rockville, Maryland</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiopulmonary Arrest</b> Due to (or as a consequence of): <b>b. Metastatic Breast Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 						29c. License number <b>D41373</b>		29d. Date signed (Month, Day, Year) <b>July 1, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Said Baidas, M.D. LCRC 3800 Reservoir Road, N.W. Washington, D.C. 20007</b>											
31. Date filed (Month, Day, Year) <b>JUL 02 1999</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22084

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Albert Lebensbaum</b>				2. Date of Death Month Day Year <b>June 28, 1999</b>		3. Time of Death <b>1:32 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-36-4154</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 20, 1906</b>	9. Birthplace (State or Foreign Country) <b>Poland</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3704 Randolph Road</b>			10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Representative</b>		16b. Kind of Business/Industry <b>Dairy Products</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Bernard Lebensbaum</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Esther Leah Pachter</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Samuel Lebensbaum (brother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>927 Monroe Avenue, Scranton, PA 18510</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dalton Jewish Cemetery</b>		20c. Location - City or Town, State <b>6-30-99 Dalton, Pennsylvania</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ziman Funeral Home 612 Gibson Street, Scranton, PA 18510</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Diabetes Mellitus</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>Minutes</b>  <b>Years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b>  <b>Dementia</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 		29c. License number <b>D 36046</b>		29d. Date signed (Month, Day, Year) <b>June 28, 1999</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John J. Merendino, Jr., M. D., 4701 Randolph Road, #216, Rockville, MD 20852</b>							
	31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH WYATT LEE

2. Date of Death

Month: June Day: 25 Year: 1999

3. Time of Death

1100

4a. Facility Name (If not institution, give street and number)

715 SWIDER LANE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

173-05-6938

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

8. Data of Birth (Month, Day, Year)

April 6, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

715 Snider Lane

10f. Zip Code

20905

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Public School Board

17. Father's Name (First, Middle, Last)

Frederick Bruiningsen

18. Mother's Name (First, Middle, Maiden Surname)

Edith Inman Wyatt

19a. Informant's Name/Relationship (Type, Print)

James Wyatt Lee, Sr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38395 Pleasant View Drive, Charlotte Hall, MD 20622

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

6-29-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D. (ONE)

29c. License number

015236

29d. Date signed (Month, Day, Year)

JUNE 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL I. MARGOLIS, M.D. (ONE) 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22086

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles M. Lennahan				2. Date of Death Month Day Year June 24, 1999				3. Time of Death 5:10 pm	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 224-60-0461		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) Oct 10, 1906		9. Birthplace (State or Foreign Country) Nebraska		Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 14803 Lindsey Lane				10f. Zip Code 20906				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meteorologist				16b. Kind of Business/Industry Federal Government		
17. Father's Name (First, Middle, Last) Patrick J. Lennahan				18. Mother's Name (First, Middle, Maiden Surname) Anne O'Hara						
19a. Informant's Name/Relationship (Type, Print) Ann Powers / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12707 Tuberville Court, Herndon, VA 20171						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date June 25 1999		20c. Location - City or Town, State Alexandria, VA				
21. Signature of Funeral Service Licensee Robert Ramsey				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, MD 20901						
23a. Part I. Enter the disease, or complications that caused a death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Stroke - Intracerebral Bleed  Due to (or as a consequence of): Atherosclerosis  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Coronary Artery Disease Peripheral Vascular Disease		Approximate Interval Between Onset and Death 6 hours 20 years								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Peripheral Vascular Disease				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier W. J. J. J.		29c. License number D31918		29d. Date signed (Month, Day, Year) JUNE 25, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARREN O. FORRIS, 3305 North Leeswood Boulevard, Silver Spring, Maryland 20906										
31. Date filed (Month, Day, Year) JUN 28 1999		32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

30





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND ITEM #5 PER F.H. G774 8-4-99 WR.

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, this Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Milton Lipnick</b>						2. Date of Death Month <b>06</b> Day <b>22</b> Year <b>99</b>		3. Time of Death <b>2:35 am</b>	
4a. Facility Name (If not institution, give street and number) <b>Hebrew Home</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>			
5. Social Security Number <b>214-32-9440</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10-27-1909</b>		9. Birthplace (State or Foreign Country) <b>Washington DC</b>	
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2001 August Drive</b>				10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chemist</b>			16b. Kind of Business/Industry <b>U.S. Government</b>		
17. Father's Name (First, Middle, Last) <b>Kain Lipnick</b>						18. Mother's Name (First, Middle, Maiden Surname)			
19a. Informant's Name/Relationship (Type, Print) <b>Lewis Lipnick/ Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3014 Barkley Gate Lane Fairfax, VA 22031</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Crematory</b>		Date <b>6/23/99</b>		20c. Location - City or Town, State <b>Falls Church, VA</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>National F.H. 7482 Lee Hwy Falls Ch. VA</b>					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Myocardial Infarction</b> Due to (or as a consequence of): <b>Coronary Artery Disease</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>				29c. License number <b>D24942</b>		29d. Date signed (Month, Day, Year) <b>June 22 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gregory A. Compton MD 6121 Montrose Rd Rockville MD</b>									
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>				32. Registrar's Signature <i>[Signature]</i>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) Suey Goon Look				2. Date of Death Month Day Year June 28, 1999		3. Time of Death 10:51 am	
4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville, MD		4c. County of Death Montgomery	
5. Social Security Number 170-38-5004		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 7, 1926	
						9. Birthplace (State or Foreign Country) China	
Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 7233 Titonka Way				10f. Zip Code 20855		10g. Citizen of What Country? China	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Kwan Wei Fong				18. Mother's Name (First, Middle, Maiden Sumama) Shih Yee			
19a. Informant's Name/Relationship (Type, Print) Gwing Y. Look, husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7233 Titonka Way, Rockville, MD 20855			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date July 3, 1999		20c. Location - City or Town, State Silver Spring, MD	
21. Signature of Funeral Service Director 				22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. RESPIRATORY ARREST Due to (or as a consequence of): b. CARDIAC ARRHYTHMIA Due to (or as a consequence of): c. CARDIOVASCULAR DISEASE Due to (or as a consequence of): d.							
23b. Approximate Interval Between Onset and Death 8 HOURS 2 HOURS YEARS							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TERMINAL METASTATIC GASTROINTESTINAL CANCER						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number D12566		29d. Date signed (Month, Day, Year) JUNE 28, 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BERNY J. KREUTZ, M.D., 10215 FERNWOOD RD., BETHESDA, MD 20817							
31. Date filed (Month, Day, Year) JUL 02 1999		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22089

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>JAMES A. MILLER</b>				2. Date of Death Month <b>06</b> Day <b>26</b> Year <b>99</b>				3. Time of Death <b>1011</b>					
4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>Randallstown</b>				4c. County of Death <b>BALTIMORE</b>					
5. Social Security Number <b>214-26-0618</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>05/22/28</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent													
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>4305 Windy Hill Road</b>				10f. Zip Code <b>21133</b>				10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plaster Contractor</b>				16b. Kind of Business/Industry <b>Construction</b>					
17. Father's Name (First, Middle, Last) <b>James Arthur Miller, Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Ida Schmier</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Dorothy B. Miller (Wife)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4305 Windy Hill Rd. Randallstown, MD 21133</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Mem. Park</b>		Date <b>6/29/99</b>		20c. Location - City or Town, State <b>Sykesville, MD</b>					
21. Signature of Funeral Service Licensee <b>Brian D. Haight</b>				22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel, P.A. (Box 195) Sykesville, MD 21784 (410)-795-1400</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiac arrest</b> Due to (or as a consequence of): <b>b. Myocardial Infarction</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>J. Kawaja</b>				29c. License number <b>025112</b>		29d. Date signed (Month, Day, Year) <b>6/28/1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TAHOORA KAWAJA 1777 Reisterstown Rd #108 Baltimore MD 21208</b>													
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature <b>B. Sparks</b>											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY MARINO</b>				2. Date of Death Month Day Year <b>JUNE 28 1999</b>		3. Time of Death <b>8:00PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-12-6411</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b>		8. Date of Birth (Month, Day, Year) <b>March 26 1911</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>Md</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Finksburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>1214 Marclee Road</b>		10f. Zip Code <b>21048</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>seamstress</b>		16b. Kind of Business/Industry <b>domestic</b>			
	17. Father's Name (First, Middle, Last) <b>Pasquale Gugliuzza</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Teresa Canclose</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Joseph Mellor (nephew)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1214 Marclee Road, Finksburg, Md 21048</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		Date <b>7-2-99</b>		20c. Location - City or Town, State <b>Baltimore, Md</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, Md 21784</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of): <b>b. PNEUMONIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>HOUSE PHYSICIAN</b>		29c. License number <b>D 42723</b>		29d. Date signed (Month, Day, Year) <b>JUNE 28TH 1999</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>AVVERA HALL M HARISH BALTIMORE MD 21236</b>								
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22091

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH ANN MILLER

2. Date of Death

Month  
JUNEDay  
30Year  
1999

3. Time of Death

1729

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

235-44-6791

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 20, 1929

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26828 Dix Street

10f. Zip Code

20872

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Newspaper Company

17. Father's Name (First, Middle, Last)

John Thomson

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Jones

19a. Informant's Name/Relationship (Type, Print)

Herbert Vance Miller - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26828 Dix Street, Damascus, Maryland 20872

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

7/3/99

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Robert L. Williams

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland

20872-0117

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

b. RENAL FAILURE

Due to (or as a consequence of):

c. DIABETES MELLITUS

Due to (or as a consequence of):

d.

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] (M.E.)

29c. License number

015236

29d. Date signed (Month, Day, Year)

JUL 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL MARGOLIS, M.D. (M.E.) 1115 ROCKVILLE PIKE, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <u>Austin Mann Miller</u>				2. Date of Death Month <u>June</u> Day <u>23</u> Year <u>1999</u>		3. Time of Death <u>3:00 AM</u>	
4a. Facility Name (If not institution, give street and number) <u>Williamsport Nursing Home</u>				4b. City, Town, or Location of Death <u>Williamsport</u>		4c. County of Death <u>Washington County</u>	
5. Social Security Number <u>213-16-0963</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>88</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>June 7, 1911</u>	
9. Birthplace (State or Foreign Country) <u>Maryland</u>		10. Usual Residence of Decedent		11. Under 1 Year Months <u>  </u> Days <u>  </u>		12. Under 24 Hrs. Hours <u>  </u> Min. <u>  </u>	

10a. State <u>Maryland</u>		10b. County <u>Washington</u>		10c. City, Town or Location <u>Hagerstown</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>18034 Putter Drive</u>				10f. Zip Code <u>21740</u>		10g. Citizen of What Country? <u>USA</u>	

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
--	--	---	--	--	--	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Electrician</u>		16b. Kind of Business/Industry <u>Railroad</u>	
---	--	---	--	---	--

17. Father's Name (First, Middle, Last) <u>Daniel Miller</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>California Willard Ahalt</u>	
---	--	--	--

19a. Informant's Name/Relationship (Type, Print) <u>Austin M. Miller, Jr., son</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7195 Peekskill Drive, Frederick, MD 21702</u>	
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mt. Olivet Cemetery</u>		20c. Location - City or Town, State <u>6/26/99 Frederick, Maryland</u>	
---	--	--	--	---	--

21. Signature of Funeral Service Licensee <u>Ryan M. Beyer</u>		22. Name and Address of Facility <u>Keeney and Basford Funeral Home</u> <u>MO0999 106 East Church Street, Frederick, MD 21701</u>	
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death	
a. <u>Pancytopenia</u> Due to (or as a consequence of):		<u>2 months</u>	
b. <u>Acute lymphoblastic Leukemia</u> Due to (or as a consequence of):		<u>2 months</u>	
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
---	--	--	--

24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
---	--	---	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28. Date of Injury (Month, Day, Year) <u>  </u> <u>  </u> <u>  </u>	
28a. Time of Injury <u>  </u> M <u>  </u>		28b. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>Cynthia Kuttner-Sands, MD</u>	
29c. License number <u>D47451</u>		29d. Date signed (Month, Day, Year) <u>June 23, 1999</u>	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Cynthia Kuttner-Sands, MD 11110 Medical Campus Road Suite 130 Hagerstown, Maryland 21742</u>	
31. Date filed (Month, Day, Year) <u>JUN 25 1999</u>	
32. Registrar's Signature <u>B. Sparks</u>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-22093

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Irene May MacALISTER</b>				2. Date of Death Month Day Year <b>June 22, 1999</b>		3. Time of Death <b>5:00 P.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Homewood Retirement Center</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>188-36-6988</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 10, 1909</b>	
9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <b>1 Yes 2 No</b>	
10e. Street and Number <b>8005 Clearfield Road</b>				10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Edward Miller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Dorn</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Jean MacAlister Flory/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8005 Clearfield Road, Frederick, Md. 21702</b>			
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Lebanon Cemetery</b>		Date <b>July 12, 1999</b>		20c. Location - City or Town, State <b>Mt. Lebanon, Penna.</b>	
21. Signature of Funeral Service Licensee <i>Richard C. C. [Signature]</i> M00021		22. Name and Address of Facility <b>Keeney &amp; Basford Funeral Home 106 East Church Street, Frederick, Md. 21701</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. CVA</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>f. 2 WKS</b> Due to (or as a consequence of):  g. Due to (or as a consequence of):  h.							Approximate Interval Between Onset and Death <b>2 WKS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>	
						24e. Was an autopsy performed? <b>1 Yes 2 No</b>	
						24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>	
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D-13971</b>		29d. Date signed (Month, Day, Year) <b>6/24/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>300 W 9th St, Frederick MD 21701</b>							
31. Date filed (Month, Day, Year) <b>JUN 25 1999</b>		32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Harry Jacob Martin, Jr. 2. Date of Death Month Day Year June 22, 1999 3. Time of Death 11:15 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital 4b. City, Town, or Location of Death Frederick 4c. County of Death Frederick

5. Social Security Number 219-20-2217 6. Sex M 20 F 7. Age (In yrs. last birthday) 74 8. Date of Birth (Month, Day, Year) August 1, 1924 9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Thurmont 10d. Inside City Limits 10 Yes 20 No

10e. Street and Number 12216 Auburn Road 10f. Zip Code 21788 10g. Citizen of What Country? U.S.A.

11. Marital Status 10 Never Married 20 Married 30 Widowed 40 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No If Yes, Give Year or Dates: 1943 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver 16b. Kind of Business/Industry Commercial Trucking

17. Father's Name (First, Middle, Last) Harry Martin 18. Mother's Name (First, Middle, Maiden Surname) Florence R. Layman

19a. Informant's Name/Relationship (Type, Print) Hallie Martin - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12216 Auburn Road, Thurmont, Maryland 21788

20a. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Lewistown Cemetery Date June 25, 20c. Location - City or Town, State Lewistown, Maryland

21. Signature of Funeral Service Licensee Sharon Camille Collier 22. Name and Address of Facility 1999 Stauffer Funeral Homes, P. A. 104 East Main St., Thurmont, Maryland 21788

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ruptured Abdominal Aortic Aneurysm Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown 24a. Was an autopsy performed? 10 Yes 20 No 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension

25. Was case referred to medical examiner? 10 Yes 20 No 26. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 10 Yes 20 No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier 29c. License number D6035152 29d. Date signed (Month, Day, Year) 6-23-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.L. Krantz, MD 100 S. Center St. Thurmont, MD 21788

31. Date filed (Month, Day, Year) JUN 24 1999 32. Registrar's Signature Geneva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended  
Line 8./SC  
6-30-99/WCHD

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marshall Bernard Northern

2. Date of Death

June 17, 1999

3. Time of Death

1:30pm

4a. Facility Name (If not institution, give street and number)

19315 Fisher Ave.

4b. City, Town, or Location of Death

Poolesville,

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-18-2808

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 19, 1918

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Poolesville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

19315 Fisher Ave.

10f. Zip Code

20837

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Metro Line

17. Father's Name (First, Middle, Last)

Benjamin Franklin Northern

18. Mother's Name (First, Middle, Maiden Summa)

Nina Marie Hall

19a. Informant's Name/Relationship (Type, Print)

Margaret Northern

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19315 Fisher Ave. Poolesville, MD. 20837

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkhead Cem.

Date

June 20, 1999

20c. Location - City or Town, State

Big Pool, MD

21. Signature of Funeral Service Licensee

*Donald Edwin Thompson*

22. Name and Address of Facility

Donald Edwin Thompson Funeral Home, Inc  
POBOX 310 Clear Spring, MD 21722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Joel Kalman M.D.*

29c. License number

D20367

29d. Date signed (Month, Day, Year)

6/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOEL KALMAN 6111 EXECUTIVE BLVD ROCKVILLE MD 20852

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

*B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 955-5555.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Edward Orton						2. Date of Death Month Day Year June 25, 1999		3. Time of Death 4:45 PM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 579-16-3254		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) July 22, 1919		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 9716 Hedin Drive				10f. Zip Code 20903		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vice President			16b. Kind of Business/Industry Real Estate				
	17. Father's Name (First, Middle, Last) John Orton						18. Mother's Name (First, Middle, Maiden Surname) Eula Flowers			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gloria S. Orton (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9716 Hedin Drive Silver Spring, Maryland 20903					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 6/30/99		20c. Location - City or Town, State Silver Spring, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. Congestive Heart Failure Due to (or as a consequence of): b. Atherosclerotic Coronary Artery Disease Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Hypercholesterolemia									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number D 24886		29d. Date signed (Month, Day, Year) June 26, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark H. Eig, M.D. 10801 Lockwood Drive Silver Spring, Maryland 20901-1557										
31. Date filed (Month, Day, Year) JUN 29 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature or mark.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22097

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jean L. Orme</b>				2. Date of Death Month <b>June</b> Day <b>25</b> Year <b>1999</b>		3. Time of Death <b>2:16PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>217-28-0178</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 16, 1930</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>13145 Dairymaid Drive - Apt. 204</b>				10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Investments Adviser</b>			16b. Kind of Business/Industry <b>Banking</b>	
17. Father's Name (First, Middle, Last) <b>James G. Muir, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Janet McKinley</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lillian M. Gilbert - Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#1 Miller Fall Court, Derwood, Maryland 20855</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Monocacy Cemetery</b>		Date <b>6/28/99</b>		20c. Location - City or Town, State <b>Beallsville, Maryland</b>
21. Signature of Funeral Service Licensee <b>Forest L. Williams</b>				22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117</b>				
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								<b>1 week</b>
Due to (or as a consequence of):								<b>1 week</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								<b>2 months</b>
Due to (or as a consequence of):								<b>4 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>lymphomatous meningitis</b> <b>perforated bowel</b> <b>pelvic abscess</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D 43083</b>		29d. Date signed (Month, Day, Year) <b>June 25, 1999</b>		
29b. Signature and title of certifier <b>George A. Sotos MD</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GEORGE A. SOTOS, MD 9707 Medical Center Drive, #300 Rockville, MD 20850</b>								
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>				32. Registrar's Signature <b>B. Sparks</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22098

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Hattie Marie PHEIL				2. Date of Death Month Day Year June 26th 1999		3. Time of Death 12:15 AM	
4a. Facility Name (If not institution, give street and number) Fahrney Keedy Nursing Home				4b. City, Town, or Location of Death Boonsboro		4c. County of Death Washington	
5. Social Security Number 220-18-1505		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 102 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 16, 1896	
9. Birthplace (State or Foreign Country) Pennsylvania							

Funeral  
Director

Usual Residence of Decedent			
10a. State Maryland		10b. County Washington	
10c. City, Town or Location Hagerstown			
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 289 Frederick Street		10f. Zip Code 21740	
10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) silk finisher	
16b. Kind of Business/Industry laundry			
17. Father's Name (First, Middle, Last) Abram Ensminger		18. Mother's Name (First, Middle, Maiden Surname) Frances Criswell	
19a. Informant's Name/Relationship (Type, Print) Mr. Francis Z. Pheil/son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 345 South Cleveland Street, Hagerstown, Maryland 21740	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery	
20c. Date June 29, 1999		20d. Location - City or Town, State Hagerstown, Maryland	
21. Signature of Funeral Service Licensee <i>Scott M. Minnich</i>		22. Name and Address of Facility Minnich Funeral Home 15 East Wilson Blvd., Hagerstown, Maryland 21740	

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <i>Alzheimer Disease</i>		Approximate Interval Between Onset and Death <i>m</i>
Due to (or as a consequence of):		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. Due to (or as a consequence of):		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arterio sclerotic Cardiovascular Disease</i>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. Vasant Datta</i>		29c. License number D18019	
		29d. Date signed (Month, Day, Year) June 26, 1999			

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Vasant Datta, 334 Mill Street, Hagerstown, Md. 21740	
--	--

31. Date filed (Month, Day, Year) JUN 28 1999		32. Registrar's Signature <i>James S. Sparks</i>	
--	--	---	--

State  
Registrar

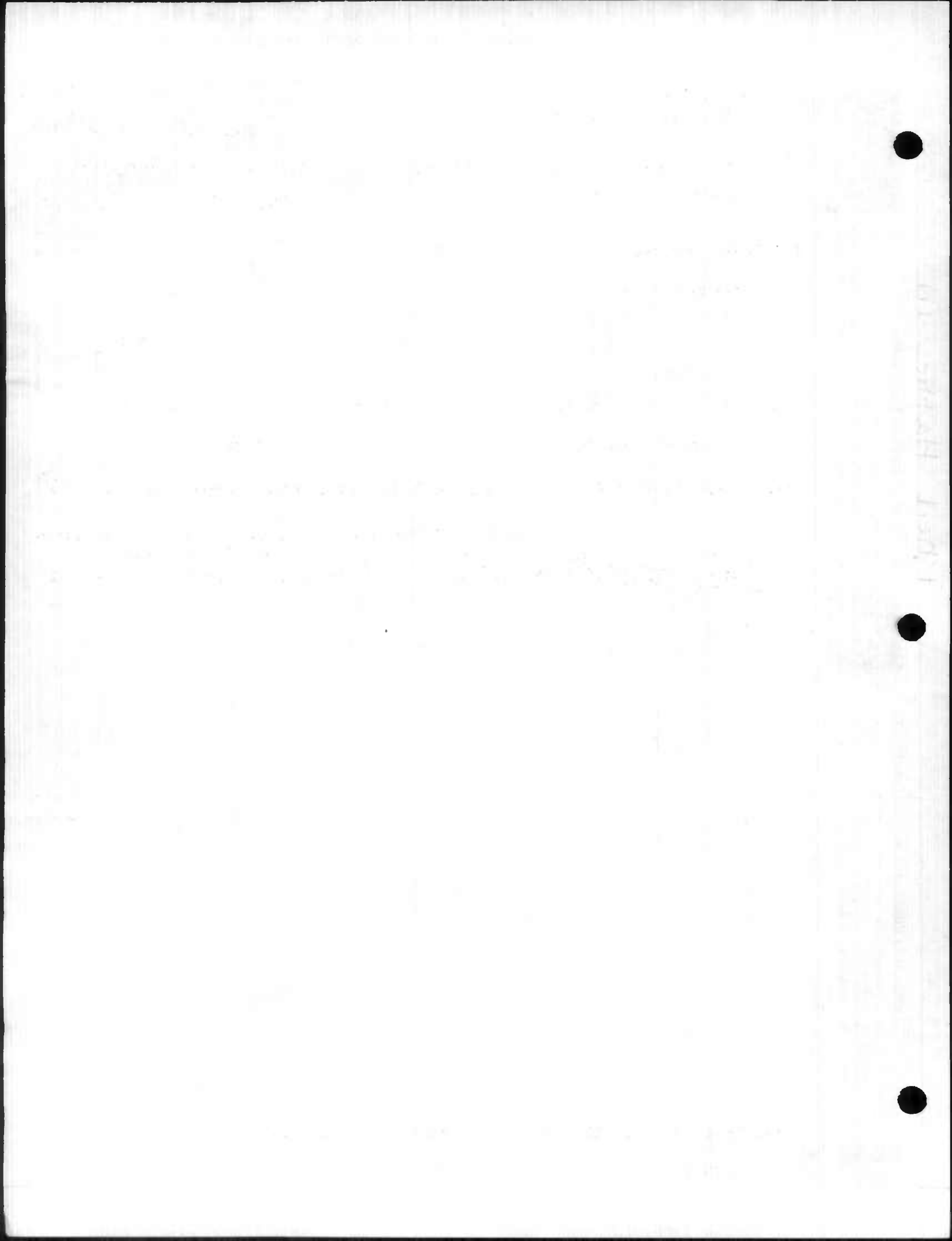
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Pheil Hattie M.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22099

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Geraldine Margaret Palmer

2. Date of Death

Month June 23, 1999

3. Time of Death

7:38AM

4a. Facility Name (If not institution, give street and number)

Colton Villa Nursing Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

354-09-3739

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 21, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

346 North Mulberry Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Key Punch Operator

16b. Kind of Business/Industry

Aircraft Mfg.

17. Father's Name (First, Middle, Last)

Roy Grove Powell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Julia Delauney

19a. Informant's Name/Relationship (Type, Print)

Paul W. Palmer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

346 North Mulberry Street, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mountain View Cemetery 06-29-99

Data

20c. Location - City or Town, State

Sharpsburg, Maryland

21. Signature of Funeral Service Licenses

R. Noel Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.  
40 East Antietam Street, Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Congestive Heart Failure

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

Alzheimer's Dementia

years

c. Due to (or as a consequence of):

Diabetes mellitus

years

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pacemaker insertion s/p Syncope  
Swallowing dysfunction status post  
gastrostomy tube placement

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

J. L. O'D.

29c. License number

D00141131

29d. Date signed (Month, Day, Year)

6/25/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JERRY L. CORRELLS, M.D.  
338 W. 8th St. Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22100

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Terry Dwaine Pittsnogle

2. Date of Death

Month Day Year

JUNE 25, 1999

Day

Year

3. Time of Death

0634

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

233-70-2475

6. Sex

1X M 2□ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

July 10, 1947

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10e. State

Md.

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1X Yes 2□ No

10e. Street and Number

502 Mitchell Ave.

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2□ Married  
3□ Widowed 4X Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1□ Yes 2X No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Appliance Co.

17. Father's Name (First, Middle, Last)

William D. Pittsnogle

18. Mother's Name (First, Middle, Maiden Surname)

Alma L. Western

19a. Informant's Name/Relationship (Type, Print)

Jeffrey D. Pittsnogle (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7512 Mountain Laurel Rd. Boonsboro, Md. 21713

20a. Method of Disposition

1□ Burial 2X Cremation 3□ Removal from State  
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

June 30, 1999 Smithsburg, Md.

21. Signature of Funeral Service Licensee

Dennis L. Davis

22. Name and Address of Facility

Davis Funeral Home  
12525 Bradbury Ave.  
Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Emboli

Due to (or as a consequence of):

b. Varicose Vein with stasis ulcer Both years

Due to (or as a consequence of):

c. legs

Due to (or as a consequence of):

d. Venous Valve Incompetent

Approximate Interval Between Onset and Death

min

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral leg extensive cellulitis

Chronic obstructive lung disease

Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4X Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2X No

Hospital:

1X Inpatient 2□ ER/Outpatient 3□ DOA

26. Place of Death (Check only one)

Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending investigation  
2□ Accident 6□ Could not be determined  
3□ Suicide 4□ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis L. Davis

29c. License number

D18727

29d. Date signed (Month, Day, Year)

6/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chia Chuen Su, M.D. 370 Mill St. Hagerstown, Md. 21740

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Harriett Alice Powell</b>				2. Date of Death Month <b>June</b> Day <b>22</b> Year <b>1999</b>				3. Time of Death <b>4:15 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>225-20-4090</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 16, 1922</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>5721 Grosvenor Lane</b>				10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Research Analyst</b>			16b. Kind of Business/Industry <b>Federal Government</b>		
17. Father's Name (First, Middle, Last) <b>Benjamin Powell</b>					18. Mother's Name (First, Middle, Maiden Summa) <b>Ida Owens</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorothea Stanley / Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2263 N. 51st Street, Philadelphia, PA 19131</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>6/26/99</b>		20c. Location - City or Town, State <b>Beltsville, MD</b>			
21. Signature of Funeral Service Licensee <i>Thomas G. Clyburn</i>				22. Name and Address of Facility <b>McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Myocardial Infarct</b> Due to (or as a consequence of):  b. <b>Hypertension</b> Due to (or as a consequence of):  c. <b>Renal Failure</b> Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Jay A. Ocwin, MD</i>				29c. License number <b>D21955</b>		29d. Date signed (Month, Day, Year) <b>June 24, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jay A. Ocwin, M.D. 1160 Varnum Street, N.E., Washington, D.C.</b>									
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>				32. Registrar's Signature <i>James B. Sparks</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1971 10

10/10/71

Dear Sir,

I am writing to you regarding the matter of the

contract for the supply of goods to the

Department of the Interior.

I am sorry that I cannot provide you with the

information you require at this time.

I am sure that you will understand the

position of the Department.

I am sure that you will be satisfied with the

arrangements made.

I am sure that you will be satisfied with the

arrangements made.

I am sure that you will be satisfied with the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22102

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William James Painter				2. Date of Death Month Day Year June 26, 1999		3. Time of Death 7:50 PM	
	4a. Facility Name (If not institution, give street and number) Collington Episcopal Life Care Community				4b. City, Town, or Location of Death Mitchellville		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 132-05-5477		6. Sex 15 M 2 F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 22, 1908	
	9. Birthplace (State or Foreign Country) Canada		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Mitchellville	
Usual Residence of Decedent		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 10450 Lottsford Road, #CC 115		10f. Zip Code 20721		
10g. Citizen of What Country? United States		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant		16b. Kind of Business/Industry Automotive Supplies		
17. Father's Name (First, Middle, Last) William Painter				18. Mother's Name (First, Middle, Maiden Surname) Martha Davey				
19a. Informant's Name/Relationship (Type, Print) Jeanne M. Steffan (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4529 Custis Drive, Rockville, MD 20853				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Date 6-28-99		20d. Location - City or Town, State Beltsville, Maryland		
21. Signature of Funeral Service Licensee Eden H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 1 week						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma of the Bladder Carcinoma of the Prostate				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
				24a. Was an autopsy performed? 1 Yes 2 No				
				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 Medical Examiner		29b. Signature and title of certifier Wm H. Y...						
29c. License number D25079		29d. Date signed (Month, Day, Year) June 28, 1999						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7404 Executive Place, #502, Seabrook, Maryland 20706								
31. Date filed (Month, Day, Year) JUN 28 1999		32. Registrar's Signature B. Sparks						

ORIGINAL



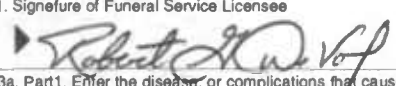
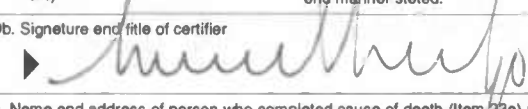

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State of Maryland / Department of Health and Mental Hygiene

Amend #17,7/7/99,BMW, Montg.Co

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ella Gillmer Peacock</b>				2. Date of Death Month Day Year <b>June 24, 1999</b>		3. Time of Death <b>7:40am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Bethesda</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>176-18-1220</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 30, 1905</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>602 Sunnybrook Terrace #1016</b>				10f. Zip Code <b>20877-4344</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Draftsman</b>			16b. Kind of Business/Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>George Albert Smyth</b> <del>William Francis Bailey Peacock, Sr.</del>				18. Mother's Name (First, Middle, Maiden Surname) <b>Adelaide Short Munhall</b>				
19a. Informant's Name/Relationship (Type, Print) <b>William F. Peacock, Jr. (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>602 Sunnybrook Terrace #1016, Gaithersburg, MD 20877</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Spring City Cemetery</b>		Date <b>6/29/99</b>		20c. Location - City or Town, State <b>Spring City, Utah</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 East Deer Park Drive</b> <b>Gaithersburg, MD 20877</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office, building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				
				29c. License number <b>H0051280</b>		29d. Date signed (Month, Day, Year) <b>June 25, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anush Dadgar, M.D. 13219 Executive Park Terrace, Germantown, MD 20874</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

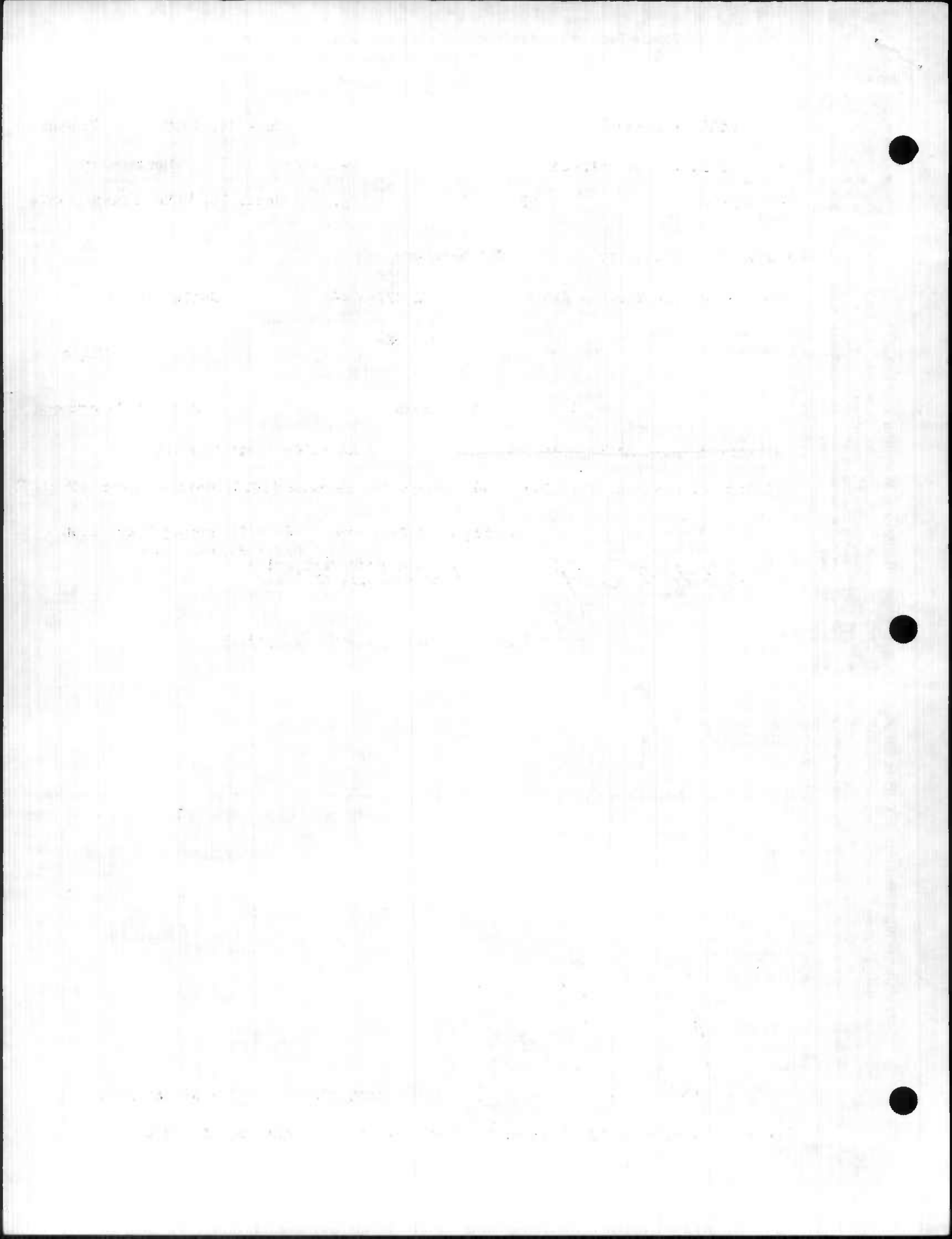
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22104

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Eugene B. Pendleton</b>				2. Date of Death Month Day Year <b>June 26, 1999</b>		3. Time of Death <b>7:55 am</b>	
4a. Facility Name (If not institution, give street and number) <b>Chevy Chase House</b>				4b. City, Town, or Location of Death <b>Chevy Chase</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>579-16-6185</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 13, 1917</b>	
9. Birthplace (State or Foreign Country) <b>Hartford, KY</b>		10a. State <b>DC</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Washington</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5420 Connecticut Ave., N.W.</b>		10f. Zip Code <b>20015</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self - Employed</b>		16b. Kind of Business/Industry <b>Private</b>		17. Father's Name (First, Middle, Last) <b>Eugene Banks Pendleton</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Lula King</b>		19a. Informant's Name/Relationship (Type, Print) <b>Barbara Jones - Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4331 Forest Lane N.W. Washington, DC 20007</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory Inc</b>		20c. Date <b>6/30/99</b>		20d. Location - City or Town, State <b>Beltsville, MD</b>		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility <b>R.N. Horton Co. Morticians, Inc. 600 Kennedy St., N.W. Washington, DC 20011</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PULMONARY FAILURE</b> Due to (or as a consequence of): <b>PULMONARY EMPHYSEMA</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
29c. License number <b>VA 0101032783</b>		29d. Date signed (Month, Day, Year) <b>June 30, 1999</b>		30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Dr. Galen Barbour, MD 50 Irving St., N.W. Washington, DC 20010</b>		31. Date filed (Month, Day, Year) <b>JUL 02 1999</b>	
32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22105

Amend #3, 7/7/99, BMW, Montg. Co

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Benjamin Perry</b>				2. Date of Death Month Day Year <b>June 27, 1999</b>		3. Time of Death PM AM <b>10:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>4420 Hallet Street</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>579-14-9052</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sep. 29, 1924</b>		9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits <b>1 Yes 2 No</b>		
10e. Street and Number <b>4420 Hallet Street</b>				10f. Zip Code <b>20853</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Foreman</b>		16b. Kind of Business/Industry <b>PEPCO</b>		
17. Father's Name (First, Middle, Last) <b>John Brewer Perry</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ethel Burrows</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Frances M. Perry (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4420 Hallet Street Rockville, Maryland 20853</b>				
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>6/28/99</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Diabetes mellitus</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. {</b> <b>c. {</b> <b>d. {</b>								Approximate Interval Between Onset and Death <b>5 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinsons</b> <b>Neuropathy</b>						23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		
						24a. Was an autopsy performed? <b>1 Yes 2 No</b>		
						24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>		
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>						
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1 Physician 2 Medical Examiner</b>		29c. License number <b>021910</b>						
29b. Signature and title of certifier <b>Peter B. Sherer MD</b>		29d. Date signed (Month, Day, Year) <b>June 28, 1999</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter B. Sherer MD 3921 Ferrara Dr Wheaton, MD 20806</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAURA B. PRITCHARD				2. Date of Death Month Day Year JUN 26 1999		3. Time of Death 0525		
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 220-40-4165		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 24 1943	9. Birthplace (State or Foreign Country) VA	
	Usual Residence of Decedent								
10a. State MD		10b. County Montgomery		10c. City, Town or Location Germantown			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 19617 Gunners Branch Rd.				10f. Zip Code 20876		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Domestic			
17. Father's Name (First, Middle, Last) Joseph Brown Walters					18. Mother's Name (First, Middle, Maiden Surname) Annie Tharpe				
19a. Informant's Name/Relationship (Type, Print) William Pritchard/spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19617 Gunners Branch Rd. Germantown, MD 20876					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Cemetery		20c. Location - City or Town, State 6/30 Rockville, MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hilton Funeral Home P.O. Box 86 Barnesville, MD 20838					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CIRRHOSIS OF LIVER Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 3 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BLUNT FACIAL TRAUMA FRACTURE LFT. MAXILLA, INFRAORBITAL RIM AND LATERAL ORBITAL WALL.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) JUNE 19, 1999		28b. Time of Injury 1800 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred HIT BY AUTO. WAS PROTESTING		28e. Location (Street and Number or Rural Route Number, City or Town, State) WATKINS RD. + Route 124				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 		29c. License number 015236		29d. Date signed (Month, Day, Year) JUN 27, 1999		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) CARL E. WAGGERS, MD. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852									
31. Date filed (Month, Day, Year) JUN 28 1999			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22107

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Charles H. Purnell, Jr.</b>				2. Date of Death Month <b>06</b> Day <b>21</b> Year <b>1999</b>		3. Time of Death <b>1340</b>	
4a. Facility Name (If not institution, give street and number) <b>9826 Hammond Rd.</b>				4b. City, Town, or Location of Death <b>Bishopville</b>		4c. County of Death <b>Worcester</b>	
5. Social Security Number <b>221-20-8868</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 21, 1936</b>	
9. Birthplace (State or Foreign Country) <b>MD</b>							
10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Bishopville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>9826 Hammond Rd.</b>				10f. Zip Code <b>21813</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>Waste Systems</b>	
17. Father's Name (First, Middle, Last) <b>Charles H. Purnell, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eliza Smith</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Bessie Mae Purnell/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9826 Hammond Rd., Bishopville, MD 21813</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Curtis UMC Cemetery</b>		Data <b>6/25/99</b>		20c. Location - City or Town, State <b>Bishopville, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC LUNG CANCER</b> Due to (or as a consequence of): <b>b. HYPERTENSION</b> Due to (or as a consequence of): <b>c. NON INSULIN DEPENDENT DIABETES</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D46257</b>		29d. Date signed (Month, Day, Year) <b>6/23/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>9714 Healthway Drive Berlin, MD 21811</b>							
31. Date filed (Month, Day, Year) <b>JUN 24 1999</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William

Kerns

Risdon, Jr.

2. Date of Death

Month

Day

Year

June 29, 1999

3. Time of Death

12:05A.

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

229-01-6758

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 11, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11214 Cedar Lane

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/President

16b. Kind of Business/Industry

Hardware Store

17. Father's Name (First, Middle, Last)

William K. Risdon, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Carrie

Ferguson

19a. Informant's Name/Relationship (Type, Print)

Amelia H. Risdon (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11214 Cedar Lane Beltsville, Maryland 20705

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 7/2/1999

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial infarction

06 28 99

Due to (or as a consequence of):

b. Ischemic cardiomyopathy

01 01 88

Due to (or as a consequence of):

c. Chronic obstructive pulmonary disease

01 01 75

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Azher Hussain M.D.

29c. License number

D0013668

29d. Date signed (Month, Day, Year)

June 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Azher Hussain, M.D. 4917 Edgewood Road College Park, Maryland 20740

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

Benjamin G. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

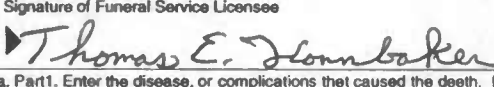
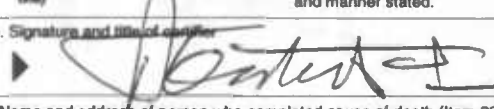

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENDED ITEM #1 PER MD G774 8/11/99 A State of Maryland / Department of Health and Mental Hygiene 99 22109  
Amended Item #1 per PhyG773 7/28/99 EW Certificate of Death Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Roland <del>Wilson</del> Romain</b>					2. Date of Death Month Day Year <b>June 25 1999</b>			3. Time of Death <b>5:28am</b>										
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>					4b. City, Town, or Location of Death <b>Bethesda</b>			4c. County of Death <b>Montgomery</b>										
<b>Funeral Director</b>	5. Social Security Number <b>577 64 3394</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 01 1937</b>		9. Birthplace (State or Foreign Country) <b>Haiti</b>										
	Usual Residence of Decedent																		
10a. State <b>Florida</b>		10b. County <b>Dade</b>		10c. City, Town or Location <b>Miami</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
10e. Street and Number <b>13876 S.W. 56 St., #297</b>					10f. Zip Code <b>33175</b>			10g. Citizen of What Country? <b>Haiti</b>											
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>OTHER</b>												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>			16b. Kind of Business/Industry <b>Academic</b>												
17. Father's Name (First, Middle, Last) <b>Louis Th. Romain</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Jeannette Edeline</b>														
19a. Informant's Name/Relationship (Type, Print) <b>Muriel A. Romain</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13876 S.W. 56 St. #297 Miami, Florida 33175</b>														
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Crematory</b>		Date <b>7/2/99</b>		20c. Location - City or Town, State <b>Falls Church, Virginia</b>												
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. N.W., Washington, D. C. 20016</b>														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td style="width:70%; vertical-align: top;"> <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td><b>Respiratory Failure</b> Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">b.</td> <td><b>Diffuse Metastatic Disease</b> Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">c.</td> <td><b>Renal Cell Carcinoma</b> Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> </tr> </table> </td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td><b>Respiratory Failure</b> Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">b.</td> <td><b>Diffuse Metastatic Disease</b> Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">c.</td> <td><b>Renal Cell Carcinoma</b> Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> </tr> </table>	a.	<b>Respiratory Failure</b> Due to (or as a consequence of):	b.	<b>Diffuse Metastatic Disease</b> Due to (or as a consequence of):	c.	<b>Renal Cell Carcinoma</b> Due to (or as a consequence of):	d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td><b>Respiratory Failure</b> Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">b.</td> <td><b>Diffuse Metastatic Disease</b> Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">c.</td> <td><b>Renal Cell Carcinoma</b> Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> </tr> </table>	a.	<b>Respiratory Failure</b> Due to (or as a consequence of):	b.	<b>Diffuse Metastatic Disease</b> Due to (or as a consequence of):	c.	<b>Renal Cell Carcinoma</b> Due to (or as a consequence of):	d.											
a.	<b>Respiratory Failure</b> Due to (or as a consequence of):																		
b.	<b>Diffuse Metastatic Disease</b> Due to (or as a consequence of):																		
c.	<b>Renal Cell Carcinoma</b> Due to (or as a consequence of):																		
d.																			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
<table border="0" style="width:100%;"> <tr> <td style="width:70%;">           24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No         </td> <td style="width:30%;">           24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No         </td> </tr> </table>										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
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Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.																			
<b>Hypo Albuminemia</b>																			
<b>Renal Failure</b>																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred										
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier 					29c. License number <b>D-42135</b>		29d. Date signed (Month, Day, Year) <b>6/25/99</b>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dany Westerband, MD. 50 W. Edmonston Dr. Rockville, Md. 20852</b>																			
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>			32. Registrar's Signature 																



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22110

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVERETT JAMES RUSSELL</b>				2. Date of Death Month Day Year <b>JUNE 22, 1999</b>		3. Time of Death <b>4:26 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>578-07-7383</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 8, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>15143 Vantage Hill Road</b>		10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Awning Company</b>				
17. Father's Name (First, Middle, Last) <b>William E. Russell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ella M. Shaw</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Kirk T. Day/Grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2203 West Palace Green Terrace, Frederick, MD 21702</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>		20d. Date <b>June 25, 1999</b>		
21. Signature of Funeral Service Licensee  <b>M01126</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>						
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebral Vascular Accident</b> Due to (or as a consequence of): <b>b. Dementia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>2 hours</b> <b>5 years</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D41994</b>		29d. Date signed (Month, Day, Year) <b>6/24/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Gerald Delgrippe, M.D. P.O. Box 310, Walkersville, Maryland 21793</b>								
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

The first part of the report is a general description of the project. It is a study of the effects of the new tax law on the economy. The study was conducted by a group of economists from the University of California. The results of the study are presented in the following sections.

The second part of the report is a detailed analysis of the data. It shows that the new tax law has had a significant impact on the economy. The economy has grown at a faster rate than in previous years. This is due to the fact that the new tax law has encouraged investment and consumption.

The third part of the report is a discussion of the implications of the study. It shows that the new tax law has had a positive impact on the economy. This is a good sign for the future of the country.

The fourth part of the report is a conclusion. It states that the new tax law has been successful in its goal of stimulating the economy. This is a good result for the government.

The fifth part of the report is a list of references. It includes the names of the authors of the study and the sources of the data.

The sixth part of the report is an appendix. It contains additional information about the study, including a list of the data sources and a list of the authors' contact information.

The seventh part of the report is a list of figures. It includes a list of the figures in the study and a list of the authors' contact information.

The eighth part of the report is a list of tables. It includes a list of the tables in the study and a list of the authors' contact information.

The ninth part of the report is a list of footnotes. It includes a list of the footnotes in the study and a list of the authors' contact information.

The tenth part of the report is a list of appendices. It includes a list of the appendices in the study and a list of the authors' contact information.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22111

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cleora Evelyn Roberson

2. Date of Death

Month Day Year  
June 28, 1999

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

817 Locust Street

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

215-26-5643

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
July 2, 1913

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

817 Locust Street

10f. Zip Code

21613

10g. Citizen of What Country?

US

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Jewelry Store

17. Father's Name (First, Middle, Last)

August Tegtmeier

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Townsend

19a. Informant's Name/Relationship (Type, Print)

C. Beckwith Roberson Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

817 Locust Street Cambridge, Maryland 21613

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dorchester Memorial Park 7/1/99

Date

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.

700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Atherosclerotic cardiovascular disease 10 yrs*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Senile dementia**Coronary Heart Disease**Diabetes Mellitus type II*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Eyup Tanman M.D.*

29c. License number

D14349

29d. Date signed (Month, Day, Year)

6-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Eyup Tanman M.D. 15 Franklin St. Cambridge, MD 21613*

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 29 1999

*B. Sparks*State  
RegistrarBaltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 22112**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>JANICE M. ROOT</b>				2. Date of Death Month <b>6</b> Day <b>15</b> Year <b>99</b>				3. Time of Death <b>12:37 A</b>			
4a. Facility Name (If not Institution, give street and number) <b>UNIV OF MARYLAND - SHOCK TRAUMA</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death			
5. Social Security Number <b>221-40-3522</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>47</b>	8. Date of Birth (Month, Day, Year) <b>MARCH 31, 1952</b>	9. Birthplace (State or Foreign Country) <b>GREENWOOD, DE</b>						
Usual Residence of Decedent											
10a. State <b>DELAWARE</b>		10b. County <b>KENT</b>		10c. City, Town or Location <b>HARRINGTON</b>				10d. Inside City Limits <b>1</b> Yes <b>2</b> No			
10e. Street and Number <b>1199 STAYTONVILLE RD.</b>				10f. Zip Code <b>19952</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>L.P.N.</b>				16b. Kind of Business/Industry <b>HOSPITAL</b>			
17. Father's Name (First, Middle, Last) <b>ELVIN SCHROCK</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>ALMA TROYER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>WILLIAM ROOT - HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1199 STAYTONVILLE RD., HARRINGTON, DE 19952</b>							
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREENWOOD MENNONITE CEM.</b>				20c. Date <b>6-18-99</b>		20d. Location - City or Town, State <b>GREENWOOD, DE</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>BERRY-SHORT FUNERAL HOME 119 NW FRONT ST., MILFORD, DE 19963</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. IDIOPATHIC PULMONARY FIBROSIS</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>										Approximate Interval Between Onset and Death <b>2 weeks</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown	
										24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No	
										24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)							
27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>Cynthia Soriano, MD</b>				29c. License number <b>00051347</b>				29d. Date signed (Month, Day, Year) <b>6/15/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>UNIV. OF MARYLAND HOSPITAL</b>											
31. Date filed (Month, Day, Year) <b>JUN 21 1999</b>				32. Registrar's Signature <i>[Signature]</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22113

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SHALENA DANNAIL STEVENS</b>				2. Date of Death Month Day Year <b>JUNE 24 1999</b>		3. Time of Death <b>1723</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>97-62-1373</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>17</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>2/24/1982</b>		9. Birthplace (State or Foreign Country) <b>PA</b>
	Usual Residence of Decedent							
10a. State <b>PA</b>		10b. County <b>Cumberland</b>		10c. City, Town or Location <b>Southampton Township</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1267 Newburg Road, Shippensburg, PA</b>				10f. Zip Code <b>17257</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>High School Student</b>			16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) <b>Edward L. Stevens, Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Donna M. Coldsmith</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edward L. Stevens, Jr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1267 Newburg Rd., Shippensburg, PA 17257</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Spring Hill Cemetery</b>		Date <b>6.29/99</b>		20c. Location - City or Town, State <b>Shippensburg, PA</b>		
21. Signature of Funeral Service Licensee <i>Joanna E. Natale</i>				22. Name and Address of Facility <b>Fogelsanger-Bricker Funeral Home, Inc. P.O. Box 336, Shippensburg, PA 17257</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>STROKE</b> Due to (or as a consequence of):  b. <b>PITUITARY TUMOR</b> Due to (or as a consequence of):  c. <b>Intracranial hypertension</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <b>3 days</b>  <b>2 years</b>  <b>2 days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Joanna E. Natale</i>				29c. License number <b>D 0052991</b>		29d. Date signed (Month, Day, Year) <b>JUNE 24, 1999</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>JOANNE E. NATALE, MD Johns Hopkins Hospital, Baltimore, MD</b>								
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature <i>Beverly S. Sparks</i>						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22114

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Doris Marie Sprecher</b>				2. Date of Death Month Day Year <b>June 28, 1999</b>		3. Time of Death <b>0952a</b>				
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown,</b>		4c. County of Death <b>Washington</b>				
Funeral Director	5. Social Security Number <b>214-28-6142</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 31, 1928</b>				
	9. Birthplace (State or Foreign Country) <b>PA.</b>		10a. State <b>MD</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown,</b>				
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>16038 National Pike</b>		10f. Zip Code <b>21740</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>residence</b>							
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Peterson</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Tracy Sprecher</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19 N. Mont Valla Ave. Hagerstown, MD 21740</b>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Lawn Park. July 1, 1999</b>		20c. Location - City or Town, State <b>Hagerstown, MD</b>							
21. Signature of Funeral Service Licensee <i>Donald Edwin Thompson</i>				22. Name and Address of Facility <b>Donald Edwin Thompson Funeral Home, Inc. PO BOX 310 Clear Spring, MD 21722</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Endometrial Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>2 years</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Michael J. McLogan</i> MD		29c. License number <b>041667</b>		29d. Date signed (Month, Day, Year) <b>6-29-99</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael J. McLogan MD 1110 Medical Campus Rd. Suite 130 Hagerstown MD</b>											
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature <i>B. Sparks</i>									

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Sprecher, Doris Marie  
Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22115  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCES RAMSAY				2. Date of Death Month Day Year JUNE 18, 1999		3. Time of Death 10:20 AM				
	4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY				
Funeral Director	5. Social Security Number 165-05-8221		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 8, 1912		9. Birthplace (State or Foreign Country) PENNSYLVANIA		
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 6121 MONTROSE ROAD				10f. Zip Code 20852		10g. Citizen of What Country? UNITED STATES					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OFFICE MANAGER			16b. Kind of Business/Industry MEDICAL				
17. Father's Name (First, Middle, Last) BENJAMIN KAUFMAN					18. Mother's Name (First, Middle, Maiden Surname) MARY HERMAN						
19a. Informant's Name/Relationship (Type, Print) ROSALEA HYMAN (DAUGHTER)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8604 PAPPAS WAY - ANNANDALE, VIRGINIA						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) HUMANITY GIFTS		Date 6/19/99		20c. Location - City or Town, State PHILADELPHIA, PA.				
21. Signature of Funeral Service Licensee Donald C. Stottmeyer					22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY ARREST Due to (or as a consequence of): b. SENILE DEMENTIA Due to (or as a consequence of): c. MALIGNANT NEOPLASIA CONNECTIVE TISSUE Due to (or as a consequence of): d. HYPOTHYROIDISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death SUDDEN 10 YEARS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Eva Morell			29c. License number D20065		29d. Date signed (Month, Day, Year) JUNE 18, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVA MORELL - 8000 EXECUTIVE BLVD. - ROCKVILLE, MARYLAND 20852											
31. Date filed (Month, Day, Year) JUN 29 1999			32. Registrar's Signature B. Sparks								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Nancy Goheen Sankey

2. Date of Death

Month Day Year  
June 20, 1999

3. Time of Death

8:00 P.M.

4a. Facility Name (If not institution, give street and number)

19310 Clubhouse Rd.

4b. City, Town, or Location of Death

Montgomery Village Montgomery

4c. County of Death

Montgomery

5. Social Security Number

343-42-2031

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 10, 1915

9. Birthplace (State or Foreign Country)

Punxsutawney, PA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

19310 Clubhouse Rd.

10f. Zip Code

20886

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Streamer Claire Goheen

18. Mother's Name (First, Middle, Maiden Surname)

Edna Grube

19a. Informant's Name/Relationship (Type, Print)

Nancy Young Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13300 Bondy Way, Darnestown, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Circle Hill Cemetery

Date

6/25/99

20c. Location - City or Town, State

Punxsutawney, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons Funeral Home, 5130 Wisconsin Ave. N.W., Washington D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Stroke

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

20 years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30844

29d. Date signed (Month, Day, Year)

June 23, 1999

30. Name and address of person who completed cause of death (Form 23e) (Type, Print)

James F. McMurry Jr. MD. 6318 Democracy Blvd., Bethesda, MD 20817

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22117

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLAUDE JUNIOR SEARCY

2. Date of Death

Month Day Year  
JUNE 28, 1999

3. Time of Death

8:46PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

515-28-6749

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
APRIL 11, 1936

9. Birthplace (State or Foreign Country)

OKLAHOMA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

WHEATON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2228 GEORGIAN WOODS PLACE

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No 1958-  
If Yes, Give  
Year or Dates: 196213. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

PROGRAM BUDGET ANALYST

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

CLAUDE SEARCY SR.

18. Mother's Name (First, Middle, Maiden Surname)

AGNES WILLIAMS

19a. Informant's Name/Relationship (Type, Print)

MRS. JOHNNIE W. SEARCY (SPOUSE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2228 GEORGIAN WOODS PLACE WHEATON, MD 20902

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HIGHLAND PARK CEMETERY

Date

7-3-99

20c. Location - City or Town, State

KANSAS CITY, KANSAS

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI 11800 NEW HAMPSHIRE  
AVENUE SILVER SPRING, MARYLAND 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

STROKE

Approximate  
Interval Between  
Onset and Death

MINUTES

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D34590

29d. Date signed (Month, Day, Year)

6-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROY FRIED M.D. KAISER OFFICE, HOLY CROSS HOSPITAL SILVER SPRING, MD

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

Roy Fried M.D.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

10+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22118

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARBARA D. SEATON				2. Date of Death Month Day Year JUNE 27, 1999		3. Time of Death 7:40 PM	
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 577-46-9798		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth Month Day Year AUG. 17, 1935	
	9. Birthplace (State or Foreign) WASHINGTON, DC		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location BETHESDA	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 10649 WEYMOUTH STREET		10f. Zip Code 20814		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PARTY PLANNER		16b. Kind of Business/Industry UPTOWN CATERERS			
	17. Father's Name (First, Middle, Last) DAVID D. DAVIS				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY LUBY			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) VICTORIA SEATON (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1261 BELLAIR ROAD - CLEARWATER, FLORIDA 34616			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. COMFORT CREMATORY		20c. Date 7/2/99		20d. Location - City or Town, State ALEXANDRIA, VIRGINIA	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. RESPIRATORY FAILURE Due to (or as a consequence of): c. AORTIC VALVE STENOSIS Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 WEEK 6 WEEKS 6 MONTHS			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE, DIABETES MELLITUS, RENAL INSUFFICIENCY, IMMOBILITY				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number D37840		29d. Date signed (Month, Day, Year) JUNE 28, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRENT A. BERGER, MD - 11125 ROCKVILLE PIKE #103 - ROCKVILLE, MARYLAND 20852							
State Registrar	31. Date filed (Month, Day, Year) JUN 30 1999		32. Registrar's Signature 					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22119

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDNA L. SHAW				2. Date of Death Month Day Year JUNE 27, 1999		3. Time of Death 11:00 P.M.	
	4a. Facility Name (If not institution, give street and number) 3302 DENSMORE COURT				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 214-03-8489		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 31, 1918	
	9. Birthplace (State or Foreign Country) WASHINGTON, D.C.		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3302 DENSMORE COURT		10f. Zip Code 20906		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) FREDERICK L. LUTES				18. Mother's Name (First, Middle, Maiden Surname) LOUISE FORNI			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) WILLIAM L. SHAW/ SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12912 SHAW PLACE SILVER SPRING, MARYLAND 20904			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) COLESVILLE CEMETERY		20c. Date 6/30/99		20d. Location - City or Town, State SILVER SPRING, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Louis L. Grant</i>				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. OVARIAN CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 YEARS
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Daniel Rosenblum, M.D.</i>				29c. License number D 04766		29d. Date signed (Month, Day, Year) JUNE 29, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL ROSENBLUM, M.D. 10400 CONNECTICUT AVE. #606 KENSINGTON, MD 20895							
State Registrar	31. Date filed (Month, Day, Year) JUN 30 1999		32. Registrar's Signature <i>B. Sparks</i>					

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

99 22120

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SADHU SINGH

2. Date of Death

Month Day Year  
JUNE 22 1999

3. Time of Death

1330

4a. Facility Name (If not institution, give street and number)

11700 OLD COLUMBIA PIKE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

NONE

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT. 9, 1931

9. Birthplace (State or Foreign Country)

INDIA

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11700 OLD COLUMBIA PIKE

10f. Zip Code

20904

10g. Citizen of What Country?

INDIA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: ASIAN INDIAN

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

AGRICULTURE

17. Father's Name (First, Middle, Last)

SHANKAR

SINGH

18. Mother's Name (First, Middle, Maiden Surname)

DARSHAM

KAUR

19a. Informant's Name/Relationship (Type, Print)

GURMIT SINGH/SON-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

6/27/99

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

M. M. Chambers MO0091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. M. Chambers

29c. License number

015236

29d. Date signed (Month, Day, Year)

JUNE 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL E. MARGAR, MD. 1115 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22121

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BOK Lim SO				2. Date of Death Month Day Year JUNE 30 1999		3. Time of Death 6:05am	
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 215-82-6415		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	8. Date of Birth (Month, Day, Year) MAY 2, 1930	9. Birthplace (State or Foreign Country) KOREA		
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location HYATTSVILLE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1378 CHILLUM RD				10f. Zip Code 20782		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: ASIAN	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLEANER		16b. Kind of Business/Industry TEXTILE			
	17. Father's Name (First, Middle, Last) CHANG RYUL YU				18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN) CHO			
	19a. Informant's Name/Relationship (Type, Print) BO SHIN SO/SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6911 LYLE ST, LANHAM, MD 20706			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NATIONAL MEMORIAL PARK		Date JUL 2		20c. Location - City or Town, State FALLS CHURCH, VA	
	21. Signature of Funeral Service Licensee <i>Louis L. Hunt</i>				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 11800 NEW HAMPSHIRE AVE, SILVER SPRING, MD 20904			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Subdural hematoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure Sepsis								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Dr. M. H. MD</i>				29c. License number RES-000		29d. Date signed (Month, Day, Year) June 30, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRA GARONZIK, MD 600 N. Wolfe Street Baltimore, Maryland								
31. Date filed (Month, Day, Year) JUL 02 1999		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22122

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Antonina

Sottile

2. Date of Death

Month Day Year  
JUNE 23 1999

3. Time of Death

3:30 PM

4a. Facility Name (If not institution, give street and number)

660 Bryants Nursery Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

217-43-7349

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99

8. Date of Birth

Month Day Year  
Feb 1, 1900

9. Birthplace (State or Foreign Country)

Sicily

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

660 Bryants Nursery Road

10f. Zip Code

20905

10g. Citizen of What Country?

Italian Citizen

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Pietro Sparacino

18. Mother's Name (First, Middle, Maiden Surname)

Carmela Caruso

19a. Informant's Name/Relationship (Type, Print)

Carmela P. Calabrese/ Grand - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

660 Bryants Nursery Road, Silver Spring, MD 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

June 28 1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd. W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark S. Rosen MD

29c. License number

D20400

29d. Date signed (Month, Day, Year)

6/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Rosen, MD

Silver Spring, MD

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22123

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Dale Story

2. Date of Death

Month  
June

Day

24

Year

1999

3. Time of Death

9:39 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

444-20-3802

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 1, 1928

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1510 R Street., N.W.

10f. Zip Code

20009

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1945-

1961

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Political Scientist

16b. Kind of Business/Industry

University

17. Father's Name (First, Middle, Last)

Samuel David Story

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude McIntyre

19a. Informant's Name/Relationship (Type, Print)

Mark A. Eddy (executor)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2315 Washington Avenue, Chevy Chase, MD 20815

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

6-26-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Ellen W. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Gastrointestinal Bleeding

48hrs.

Due to (or as a consequence of):

b. Mallory Weiss Tear

48 hours

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. J. Reagan M.D.

29c. License number

D45121

29d. Date signed (Month, Day, Year)

June 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian F. Reagan, M. D., 1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22124

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA ELIZABETH STROMBERG				2. Date of Death Month Day Year JUNE 27, 1999		3. Time of Death 12:55 AM	
	4a. Facility Name (If not institution, give street and number) Sunrise Assisted Living				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 578-12-5212		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 22, 1904	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 990 Waterford Drive #311		10f. Zip Code 21702		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Harry Grime LeDane	
	18. Mother's Name (First, Middle, Maiden Surname) Sarah Belle Lipscomb		19a. Informant's Name/Relationship (Type, Print) Wayne Jerman (Grandson)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16910 Hoskinson Road, Poolesville, MD 20837		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Date 6/29/99		20d. Location - City or Town, State Suitland, Maryland		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877		23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ALZHEIMER'S DEMENTIA Due to (or as a consequence of):		Approximate Interval Between Onset and Death 5 yrs		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ASSISTED LIVING FACILITY		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D47611		29d. Date signed (Month, Day, Year) JUNE 27, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL WARRICK MD 1475 TANEY AVE #204 FREDERICK MD 21702		31. Date filed (Month, Day, Year) JUN 29 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22125

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL SWEENEY</b>				2. Date of Death Month Day Year <b>JUNE 29 1999</b>				3. Time of Death <b>3:15pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>290-18-5700</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) <b>Aug. 20, 1922</b>		9. Birthplace (State or Foreign Country) <b>Ohio</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10a. Street and Number <b>1220 East West Highway #1704</b>				10f. Zip Code <b>20910</b>				10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Negro</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4 +</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chief Pharmacist</b>				16b. Kind of Business/Industry <b>Medicine</b>	
	17. Father's Name (First, Middle, Last) <b>John Sweeney</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edna Gray</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Mary B. Sweeney / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1220 East West Highway, Silver Spring, MD 20910</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>7/1/99</b>		20c. Location - City or Town, State <b>Beltsville, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIOMYOPATHY</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c. BPE THERMIA</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>								Approximate Interval Between Onset and Death <b>~ 2-3 yrs</b> <b>~ 4-5 yrs</b> <b>7 days</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RENAL FAILURE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Theodore B. Spahr MD</i>				29c. License number <b>20052927</b>		
29d. Date signed (Month, Day, Year) <b>JUNE 29 1999</b>				29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE G. WEBB, WASHINGTON ADVENTIST HOSPITAL - TAKOMA PARK</b>						
30. Date filed (Month, Day, Year) <b>JUL 01 1999</b>				31. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22126

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willard Lee SPONAUGLE				2. Date of Death Month Day Year June 28, 1999		3. Time of Death 11:32am			
	4a. Facility Name (If not institution, give street and number) 3065 Big Woods Road				4b. City, Town, or Location of Death Ijamsville		4c. County of Death Frederick			
Funeral Director	5. Social Security Number 233-64-2095		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 22, 1942		9. Birthplace (State or Foreign Country) W. Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Ijamsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 3065 Big Woods Rd.				10f. Zip Code 21754		10g. Citizen of What Country? United States			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 60-64		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fireman			16b. Kind of Business/Industry Fire Department Government				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Harold Arthur Sponaugle				18. Mother's Name (First, Middle, Maiden Surname) Beulah Scott					
	19a. Informant's Name/Relationship (Type, Print) Judith Ann Sponaugle / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3065 Big Woods Rd. / Ijamsville, MD 21754					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date 6-30-99		20c. Location - City or Town, State Hagerstown, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike / Frederick, MD 21702					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death Years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number D35164		29d. Date signed (Month, Day, Year) June 28, 1999	
	30. Name and address of person who completed cause of death (Item 29a) (Type, Print) Andrew Zarick, Jr., M.D., 1080 West Patrick Street, Frederick, Maryland 21703									
State Registrar	31. Date filed (Month, Day, Year) JUL 02 1999		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

99 22127

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Jane Shields				2. Date of Death Month Day Year June 27, 1999		3. Time of Death 6:30 a.m.	
	4e. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick County	
Funeral Director	5. Social Security Number 231-58-0036		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) June 19, 1943	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 7904 Juniper Drive		10f. Zip Code 21702		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Manager		16b. Kind of Business/Industry Bank			
	17. Father's Name (First, Middle, Last) George Russell Jenkins				18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Woodburn			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Herbert M. Smaha, fiance'				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7904 Juniper Drive, Frederick, MD 21702			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State 6/30/99 Frederick, Maryland			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Ryan M. Berger MO0999				22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) e. metastatic melanoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 4 years
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Elhamy Eskander, MD				29c. License number D 48184		29d. Date signed (Month, Day, Year) 6/27/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy Eskander, MD 501 W 7th Street Frederick, MD 21701							
State Registrar	31. Date filed (Month, Day, Year) JUN 28 1999				32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



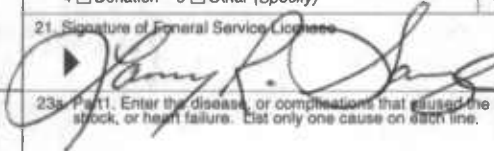
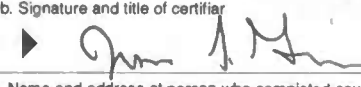
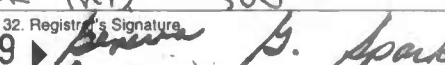


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22128

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Cecilia Elaine Settle</b>				2. Date of Death Month: <b>June</b> Day: <b>24</b> Year: <b>1999</b>		3. Time of Death <b>4:25 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>579-40-9981</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 4, 1931</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Middletown</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2415 Tabor Drive</b>				10f. Zip Code <b>21769</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Food and Drug Adm.</b>	
17. Father's Name (First, Middle, Last) <b>Alfred Hurley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Kennedy</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carl B. Settle, husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2415 Tabor Drive Middletown, Maryland 21769</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate Of Heaven</b>		Date <b>6/28/99</b>		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702</b>				
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Adenocarcinoma of gall bladder, widespread</b> Due to (or as a consequence of): <b>2 wks.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Rheumatoid Arthritis, 25 yrs.</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rheumatoid Arthritis, 25 yrs.</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D21944</b>		29d. Date signed (Month, Day, Year) <b>6/24/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jane S. Grison MD 300 W 9th St. Frederick, Md. 21701</b>								
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22129

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Marie Smith

2. Date of Death

Month Day Year  
June 21, 1999

3. Time of Death

2:15 PM

4a. Facility Name (If not institution, give street and number)

3231 Bidle Rd.

4b. City, Town, or Location of Death

Middletown

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

212-20-1398

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 11, 1921

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

MD.

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3231 Bidle Rd.

10f. Zip Code

21769

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Charles Edward Via

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Frances Callaghan

19a. Informant's Name/Relationship (Type, Print)

Donald F. Smith (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3231 Bidle Rd., Middletown, MD. 21769

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Smithsburg Crematory

Date

6/22

20c. Location - City or Town, State

Smithsburg, MD. 21769

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home  
31 E. Main St., Middletown, MD. 2176923a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

METASTATIC ADENOCARCINOMA OF THE COLON

Approximate  
Interval Between  
Onset and Death

1 1/2 YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number

D 31761

29d. Date signed (Month, Day, Year)

6/24/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BRIAN M. O'CONNOR, MD 501 W. SEVENTH ST. FREDERICK, MD 21701

31. Date filed (Month, Day, Year)

JUN 24 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

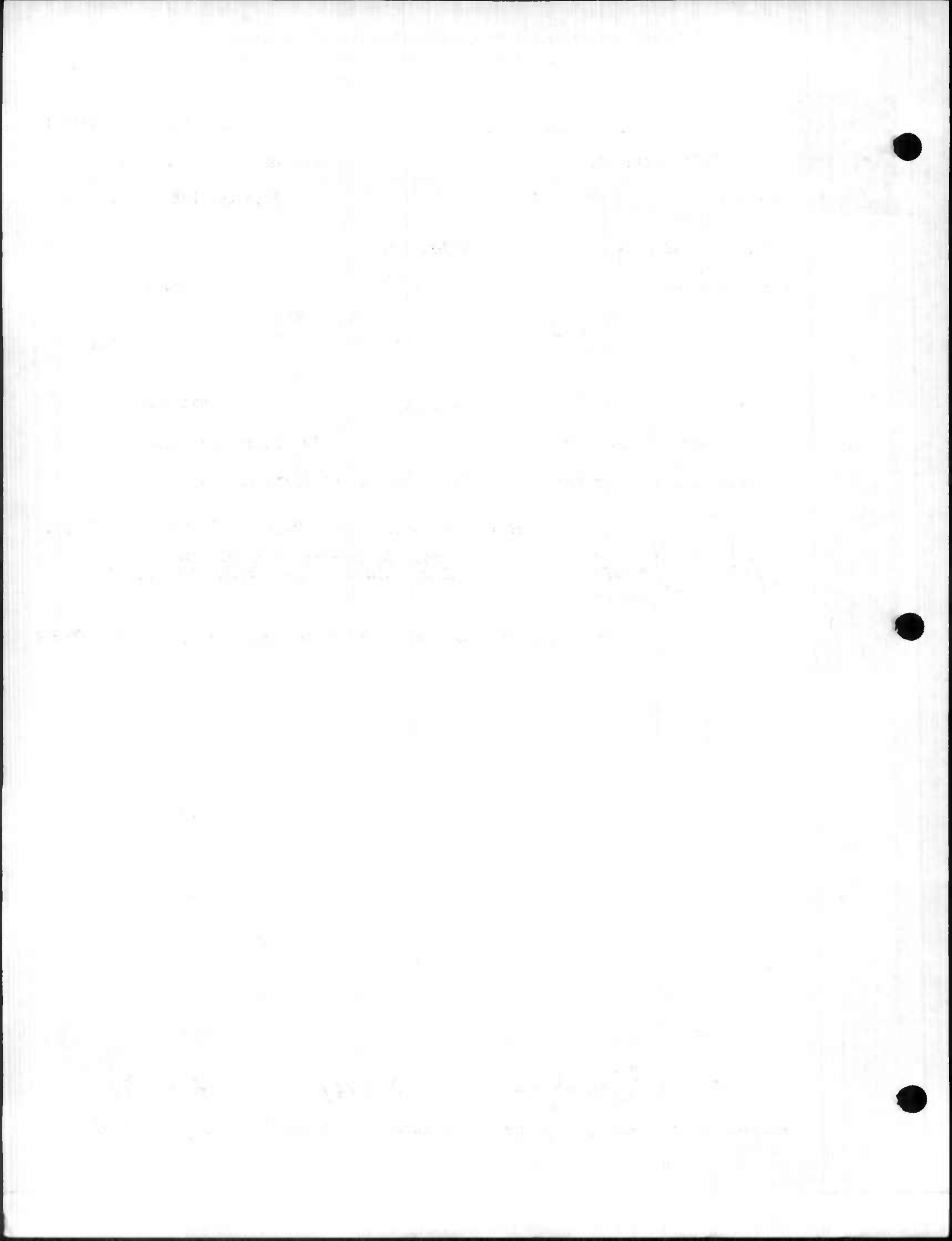
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22130

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGINIA WILSON SHOCKLEY</b>				2. Date of Death Month Day Year <b>June 22, 1999</b>		3. Time of Death <b>6:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3911 Devonshire Drive</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>219-34-2864</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b>		8. Date of Birth (Month, Day, Year) <b>June 10, 1907</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>3911 Devonshire Drive</b>		10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>4</b>		16. Kind of Business/Industry <b>Public Education</b>		17. Father's Name (First, Middle, Last) <b>John Casey Wilson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Beauchamp</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Wilma Azar/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3911 Devonshire Dr., Salisbury, MD 21804</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parsons Cemetery</b>		20c. Date <b>6/25/99</b>		20d. Location - City or Town, State <b>Salisbury, MD</b>		
21. Signature of Funeral Service Licensee <i>David H. Thompson</i> MC1051		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lymphoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Mary Fleury</i>		29c. License number <b>D24871</b>		29d. Date signed (Month, Day, Year) <b>6/22/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Mary Fleury 560 Riverside Dr., Salisbury, MD</b>								
31. Date filed (Month, Day, Year) <b>JUN 23 1999</b>		32. Registrar's Signature <i>Sparks</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

*[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22131

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN F. SUDA</b>				2. Date of Death Month <b>6</b> Day <b>14</b> Year <b>99</b>		3. Time of Death <b>0950</b>		
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>		
Funeral Director	5. Social Security Number <b>189-26-7381</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>FEB. 8, 1936</b>	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>	
	Usual Residence of Decedent				10c. City, Town or Location <b>REHOBOTH BEACH</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10a. State <b>DELAWARE</b>		10b. County <b>SUSSEX</b>		10e. Street and Number <b>59 SUSSEX STREET APT. 5</b>		10f. Zip Code <b>19971</b>		
	10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>1956-58</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1956-58</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESPERSON</b>		16b. Kind of Business/Industry <b>HARDWARE STORE</b>		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	17. Father's Name (First, Middle, Last) <b>JOHN J. SUDA</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARIAN SHABELSKI</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>DEB ROMICH</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>118 HEATHER HILL DRIVE, DOWNINGTOWN, PA 19335</b>				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EASTERN SHORE CREMATORIUM</b>		20c. Location - City or Town, State <b>LEWES, DELAWARE</b>		20d. Date <b>06/16/99</b>		
	21. Signature of Funeral Service Licensee <b>MO0866</b> <i>[Signature]</i>		22. Name and Address of Facility <b>PARSELL FUNERAL HOMES &amp; CREMATORIUM 1449 KINGS HIGHWAY, LEWES, DE 19958</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b> Due to (or as a consequence of): <b>PERFORATED DUODENAL ULCER</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Nicholas C Ogburn MD</i>		29c. License number <b>D34593</b>		29d. Date signed (Month, Day, Year) <b>6/14/99</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Nicholas Ogburn 201 Pine Bluff Rd, Suite 25, Salisbury, MD 21801</b>		31. Date filed (Month, Day, Year) <b>JUN 21 1999</b>						32. Registrar's Signature <i>[Signature]</i>	



RECEIVED  
JUN 1 1964

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22132

AMEND ITEMS: #4A, 23 PART I, II, 27 PER MEO G773

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Barbara Jean SEABOLT</b>				2. Date of Death Month Day Year <b>June 30, 1999</b>				3. Time of Death <b>5:20 A.M.</b>					
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b> <b>HAGERSTOWN</b>				4c. County of Death <b>Washington</b>					
Funeral Director	5. Social Security Number <b>215-62-7303</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>43</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>July 4, 1955</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent													
10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Sharpsburg</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>5011 General Stuart Court</b>						10f. Zip Code <b>21782</b>				10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>				16b. Kind of Business/Industry <b>her own home</b>				
17. Father's Name (First, Middle, Last) <b>Frederick Roberts, Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Cameron Dennis</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Roger L. Seabolt - husband</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5011 General Stuart Ct., Sharpsburg, Md. 21782</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery</b>		Date <b>7-3-99</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>MINNICH FUNERAL HOME</b> <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>												Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>FATTY LIVER</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and Title of certifier 						29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>July 01, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Theodor M. King</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>														
31. Date filed (Month, Day, Year) <b>JUN 12 1999</b>				32. Registrar's Signature 										

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22133

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY ALICE THUMMA</b>				2. Date of Death Month <b>June</b> Day <b>27</b> , Year <b>1999</b>		3. Time of Death <b>2:10 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Avalon Manor Health Care Center</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>214-09-5669</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 29, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>17600 Broadfording Road</b>				10f. Zip Code <b>21740</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Upper Cutter</b>		16b. Kind of Business/Industry <b>Shoe Company</b>		
17. Father's Name (First, Middle, Last) <b>Clarence Albert Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Elizabeth Hartman</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Peggy I. Reid</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17600 Broadfording Road, Hagerstown, Md. 21740</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		Date <b>06-30-99</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>		
21. Signature of Funeral Service Licensee <b>R. Noel Brady</b>				22. Name and Address of Facility <b>Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Cardiome right lung</b> Due to (or as a consequence of):  <b>Chronic obstructive Pulmonary Disease</b> <b>Hypertensive Interstitial Cardiac Disease</b> <b>Disease</b> Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>2 weeks</b> <b>2 yrs</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive Pulmonary Disease</b> <b>Hypertensive Interstitial Cardiac Disease</b> <b>Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>018015</b>		29d. Date signed (Month, Day, Year) <b>June 28, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Vasant Datta MD 334 Mill Street, Hagerstown, MD 21740</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature <b>[Signature]</b>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22134

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cecil Lester Taylor, Jr.				2. Date of Death Month Day Year June 24 1999				3. Time of Death 1610		
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 225-36-9483		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) November 22, 1931		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Montgomery County		10c. City, Town or Location Gaithersburg				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 44 Dalamar Street, Apartment 1				10f. Zip Code 20877		10g. Citizen of What Country? United States of America					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Officer				16b. Kind of Business/Industry Mall Retail Protection			
17. Father's Name (First, Middle, Last) Cecil Lester Taylor, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Tilda Mae Jenkins							
19a. Informant's Name/Relationship (Type, Print) Jeffery Taylor /Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Dalamar Street #1, Gaithersburg, Maryland 20877							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethlehem Cemetery		Data June 27, 1999		20c. Location - City or Town, State Stanley, Virginia					
21. Signature of Funeral Service Licensee #M00690 ► <i>Howard Hansen</i>				22. Name and Address of Facility The Bradley Funeral Home, Inc. 187 East Main Street, Luray, Virginia 22835							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <i>Renal failure</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension, Diabetes mellitus, CVA,</i> <i>Plural effusion</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier ► <i>Paul E. Physician</i>									
29c. License number D0052255		29d. Date signed (Month, Day, Year) June 24, 1999									
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>M. E. M.D. 8609 2nd Ave #404B Silver Spring MD 20910</i>											
31. Date filed (Month, Day, Year) JUN 29 1999		32. Registrar's Signature <i>B. Sparks</i>									

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

*[Faint, illegible text covering the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22135

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel Marion Terzick

2. Date of Death

Month Day Year  
June 28, 1999

3. Time of Death

3:20 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

531-20-8629

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 31, 1905

9. Birthplace (State or Foreign Country)

Washington

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

416 Northwest Drive

10f. Zip Code

20901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public School

17. Father's Name (First, Middle, Last)

John Hawkins

18. Mother's Name (First, Middle, Maiden Summa)

Ellen Frances (unavailable)

19a. Informant's Name/Relationship (Type, Print)

Jane T. Varner (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

54 760 South 20th Street, Purcellville, VA 20132-3307

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

6-29-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Delm

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Approximate Interval Between Onset and Death

5 minutes

Due to (or as a consequence of):

b. Congestive Heart Failure

2 days

Due to (or as a consequence of):

c. Sepsis

5 days

Due to (or as a consequence of):

d. Urinary Tract Infection

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jatinder Singh Sekhon

MD

29c. License number

D 051714

29d. Date signed (Month, Day, Year)

June, 28, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jatinder Singh Sekhon, M.D., 2401 Research Blvd., Rockville, MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22136

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Mitchell Tufty				2. Date of Death Month Day Year June 30, 1999				3. Time of Death 6:05PM	
	4a. Facility Name (If not Institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 225-68-3394		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 3, 1948		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent				10c. City, Town or Location Rockville		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. State Maryland		10b. County Montgomery		10f. Zip Code 20851		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Systems Analyst		16b. Kind of Business/Industry Self-Employed				
17. Father's Name (First, Middle, Last) Harold Guilford Tufty				18. Mother's Name (First, Middle, Maiden Surname) Edith Henry						
19a. Informant's Name/Relationship (Type, Print) Margaret M. Tufty				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Grandin Avenue, Rockville, MD 20851						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 7-2-99		20c. Location - City or Town, State Beltsville, MD				
21. Signature of Funeral Service Licensee Carol A. Del...				22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue Silver Spring, MD 20910						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cardiac Arrest Due to (or as a consequence of):  b. Life Threatening Arrhythmia Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death Immediate						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D0054139		29d. Date signed (Month, Day, Year) June 30, 1999				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Duc Le, 9901 Medical Center Dr., Rockville, MD 20850										
31. Date filed (Month, Day, Year) JUL 02 1999		32. Registrar's Signature [Signature]								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22137

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN FRANKLIN TINNEY JR.

2. Date of Death

Month

Day

Year

June 26, 1999

3. Time of Death

4:30 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4445 Fishers Hollow Road

4b. City, Town, or Location of Death

Myersville

4c. County of Death

Frederick

5. Social Security Number

217-30-7197

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 15, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Myersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4445 Fishers Hollow Road

10f. Zip Code

21773

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 59 - 65

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Brick Layer

16b. Kind of Business/Industry

Masonry Construction

17. Father's Name (First, Middle, Last)

Benjamin Franklin Tinney, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Laura Virginia May

19a. Informant's Name/Relationship (Type, Print)

Mary Tinney/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4445 Fishers Hollow Road, Myersville, MD 21773

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Ch of Breth Cemt 6/29/99

Date

20c. Location - City or Town, State

Harmony, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

504 Main Street  
Ricketts Funeral Home Myersville, MD 21773

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Extensive Bronchogenic CA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebro vascular insufficiency

hyper-coagulable state

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D1462C

29d. Date signed (Month, Day, Year)

June 28, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

V A Truscus 501 W 7th St - Frederick MD

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22138

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ASHLEY ELIZABETH TAMBURRI</b>				2. Date of Death Month <b>June</b> Day <b>24</b> , Year <b>1999</b>		3. Time of Death <b>10:53 pm</b>	
	4a. Facility Name (If not Institution, give street and number) <b>6927 Fox Chase Road</b>				4b. City, Town, or Location of Death <b>New Market</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>260-45-7271</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>16</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 23, 1982</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>New Market</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. Street and Number <b>6927 Fox Chase Road</b>				10f. Zip Code <b>21774</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <b>Greg Anthony Tamburri</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Darlene Yates</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Darlene Yates Armacost, mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6927 Fox Chase Road New Market, Maryland 21774</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hagerstown Crematory</b>		20c. Date <b>6/28/99</b>		20d. Location - City or Town, State <b>Hagerstown, Maryland</b>
21. Signature of Funeral Service Licensee <b>Marianne H. Stauffer</b>				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <b>Cerebral edema</b> Due to (or as a consequence of):  b. <b>Brainstem glioma</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death  <b>2 wks</b>  <b>1 yr</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>014626</b>		29d. Date signed (Month, Day, Year) <b>June 25/1999</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. G. Trause 501 W N 5th St Frederick MD 21701</b>								
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main points of the report and a final statement about the importance of the research.

6. The sixth part of the report is a list of references. It includes a list of all the sources used in the study, including books, articles, and other documents.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Fitzhugh Travers					2. Date of Death Month Day Year June 26, 1999		3. Time of Death 7:58 A.M.			
	4a. Facility Name (If not institution, give street and number) Dorchester General Hospital					4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester			
Funeral Director	5. Social Security Number 218-20-8820		6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Jan 30, 1927		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10e. State Maryland		10b. County Dorchester		10c. City, Town or Location Crapo				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 2424 Andrews Road					10f. Zip Code 21626		10g. Citizen of What Country? US				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Shirt Factory				
17. Father's Name (First, Middle, Last) Julian Horatio Willey					18. Mother's Name (First, Middle, Maiden Surname) Margaret Mildred Stewart						
19a. Informant's Name/Relationship (Type, Print) C. Julian Fitzhugh Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5428 Cassons Neck Road Cambridge, Maryland 21613						
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Memorial Park		Date 6/30/99		20c. Location - City or Town, State Cambridge, Maryland				
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multiple Injuries</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <i>instant</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) 6/26/99		28b. Time of Injury 705A M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>motor vehicle accident</i>		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>street</i>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>1316 Hudson Rd Cambridge, Md</i>								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Dennis J. Chute</i>					29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 27, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dennis J. Chute MD</i> 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JUN 29 1999			32. Registrar's Signature <i>B. Sparks</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22140

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Bianco Vetter

2. Date of Death

Month  
June

Day

26

Year

1999

3. Time of Death

7:35AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7716 Baederwood Terrace

4b. City, Town, or Location of Death

Derwood

4c. County of Death

Montgomery

5. Social Security Number

579-60-9701

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 4, 1952

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7716 Baederwood Terrace

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Executive Assistant

16b. Kind of Business/Industry

Property Management

17. Father's Name (First, Middle, Last)

Stewart Thomas Bianco

18. Mother's Name (First, Middle, Maiden Surname)

Joyce Cottler

19a. Informant's Name/Relationship (Type, Print)

Cleveland Brower Vetter (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7716 Baederwood Terrace, Derwood, MD 20855

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

6-28-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Eden L. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Adenocystic Carcinoma

Approximate Interval Between Onset and Death

9 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carolyn B. Hendricks MD

29c. License number

D 37236

29d. Date signed (Month, Day, Year)

June 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carolyn B. Hendricks, M.D. 5454 Wisconsin Avenue, #1345 Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22141

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANDAL

VENKATA CHALAN

2. Date of Death

Month 6 Day 25 Year 99

3. Time of Death

11:50 PM

4a. Facility Name (If not institution, give street and number)

12210 QUADRILLE LANE

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

419-37-2958

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 14, 1924

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12210 Quadrille Lane

10f. Zip Code

20720

10g. Citizen of What Country?

India

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Indian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

B. Ramanuja Iyengar

18. Mother's Name (First, Middle, Maiden Surname)

Sheshadramma Srinivasa

19a. Informant's Name/Relationship (Type, Print)

Belur Dasarathy (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1313 Chandler Road, Huntsville, AL 35801

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

6-26-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

CONGESTIVE HEART FAILURE

1 month

Due to (or as a consequence of):

CORONARY ARTERY DISEASE

3 YEARS

Due to (or as a consequence of):

ACUTE RESPIRATORY FAILURE

1 DAY

Due to (or as a consequence of):

CEREBROVASCULAR ACCIDENT

1 DAY

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA BREAST

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide  
8 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

VP Singh Attend. Phys.

29c. License number

D19897

29d. Date signed (Month, Day, Year)

6.26.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. SINGH 7209A HANOVER PARKWAY GREENBELT MD. 20770

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22142

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jakrarat Veerasarn</b>				2. Date of Death Month Day Year <b>June 23, 1999</b>		3. Time of Death <b>11:06 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>217-92-6526</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>45</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>December 21, 1953</b>	
	9. Birthplace (State or Foreign Country) <b>Thailand</b>		10a. State <b>None</b>		10b. County <b>None</b>		10c. City, Town or Location <b>Washington, D.C.</b>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>443 Eye Street, N.W.#2</b>		10f. Zip Code <b>20001</b>		
10g. Citizen of What Country? <b>Thailand</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Photographer</b>		16b. Kind of Business/Industry <b>Photography</b>		
17. Father's Name (First, Middle, Last) <b>Wirat Veerasarn</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Thussanee Sukhonthatam</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Belle E. McQuail/Partner</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>443 Eye Street, N.W. #2, Washington, D.C. 20001</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>		20d. Date <b>June 26, 1999</b>		
21. Signature of Funeral Service Licensee  M00846		22. Name and Address of Facility <b>Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of):  b. <b>Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D15236</b>		29d. Date signed (Month, Day, Year) <b>June 24, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Carl I. Margolis, M.D. (OME), 11125 Rockville Pike, Rockville, Maryland 20852</b>								
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State  
Registrar

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

99 22143

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frances Ruth WEMPE				2. DATE OF DEATH MONTH DAY YEAR June 23, 1999				3. TIME OF DEATH 9:20 a.m.					
4. SOCIAL SECURITY NUMBER 220-05-6045		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 15, 1920		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 911 Frederick Street						9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 911 Frederick Street						10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife				16b. KIND OF BUSINESS/INDUSTRY her own home					
17. FATHER'S NAME (First, Middle, Last) David Earl Wolf, Sr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian I. English							
19a. INFORMANT'S NAME (Type/Print) Martin E. Wempe - husband						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Frederick St., Hagerstown, Md. 21740							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery				DATE 6-26-99		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Carcinoma of rectum</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 years													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER A23623		29d. DATE SIGNED (Month, Day, Year) June 25, 1999					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frederic H. Kass III MD 11111 Medical Campus Rd Hagerstown													
31. DATE FILED (Month, Day, Year) JUN 25 1999				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





State of Maryland / Department of Health and Mental Hygiene 99 22144

## Reg. No.

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22145

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEANETTE R. WILLIAMS

2. Date of Death

June 27 Day 1999 Year

3. Time of Death

6:15 am

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

228-28-8489

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 29 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

333 Russell Avenue, #209

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (14 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

John Roberts

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Ann Jenkins

19a. Informant's Name/Relationship (Type, Print)

Nancy W. Pugh / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10244 Sundance Court, Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

6/28/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

Muriel H. Barber Funeral Home  
P. O. Box 5038, Laytonsville, Maryland 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive heart failure

Due to (or as a consequence of):

acute myocardial infarction

Due to (or as a consequence of):

coronary atherosclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 mo

1 mo

unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

mitral valve disease

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Barber

29c. License number

014660

29d. Date signed (Month, Day, Year)

June 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald Gager 15001 Dufief Mill Rd, Gaithersburg, Maryland 20878

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

Shirley B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22146

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Virginia Hinckle Wenner

2. Date of Death

June 25 1999

3. Time of Death

6:59 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

218-01-0326

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 20 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State  
MD

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

414 Ninth Avenue

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Thomas Franklin Hinckle

18. Mother's Name (First, Middle, Maiden Surname)

Eva Bohrer

19a. Informant's Name/Relationship (Type, Print)

Linda Nelson, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23 Petersville Road, Brunswick, MD 21716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Park Heights Cemetery

Date

6/29

20c. Location - City or Town, State

Brunswick, MD

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home  
100 Petersville Road Brunswick MD 2171623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. S. Williams

29c. License number

D 21648

29d. Date signed (Month, Day, Year)

6-25-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KUSAY BARAKAT 310 W 9th Street Frederick MD 21701

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

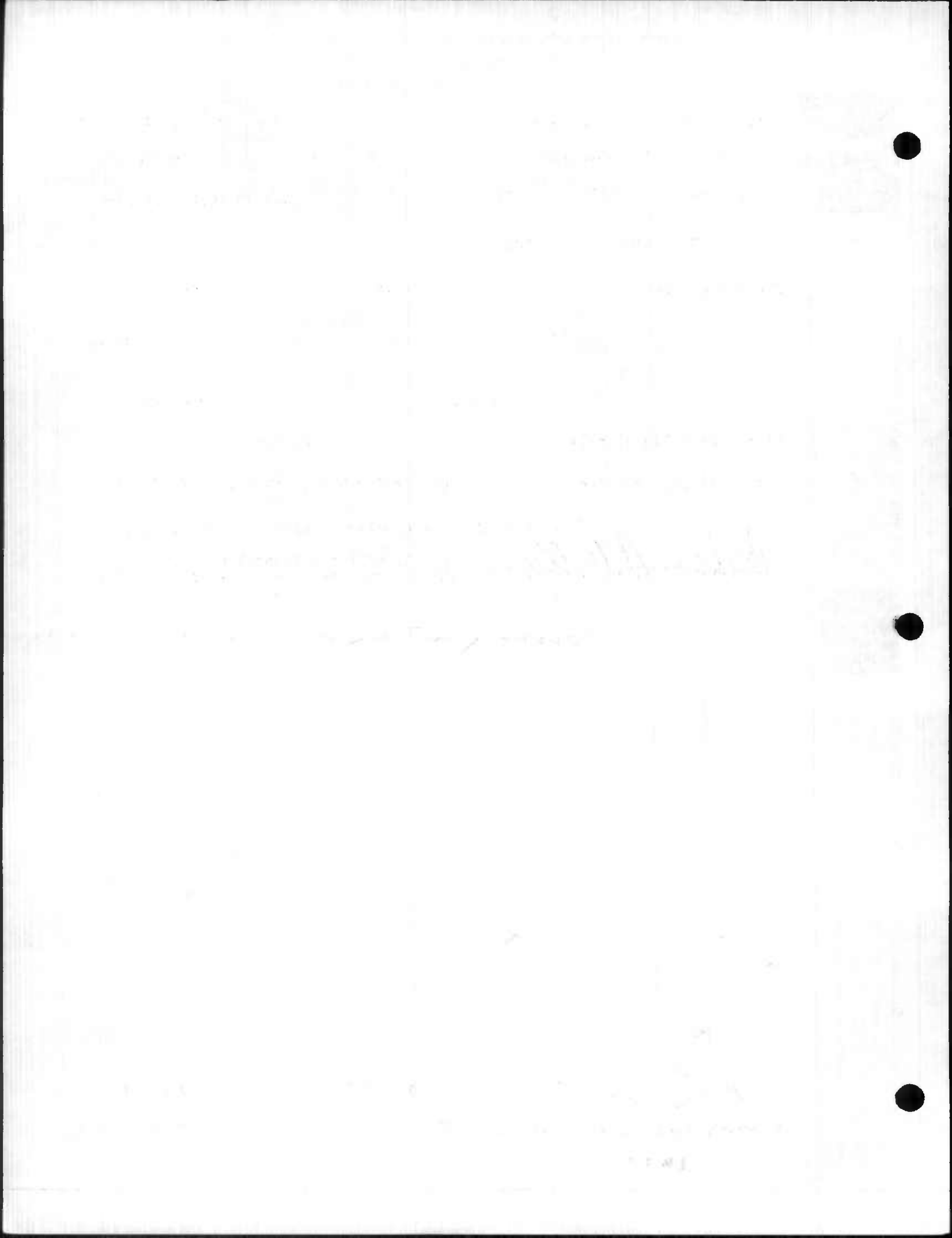
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22147

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna E. Wilson</b>				2. Date of Death Month Day Year <b>June 22, 1999</b>				3. Time of Death <b>12:35 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Rockville</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>171-50-3141</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>99</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 13, 1899</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Damascus</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. Street and Number <b>10517 Bethesda Church Road</b>				10f. Zip Code <b>20872</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own home</b>		
17. Father's Name (First, Middle, Last) <b>Andrew Johnson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ida McPherson</b>						
19a. Informant's Name/Relationship (Type, Print) <b>John Robert Klose - Grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3411 Livingston Drive, Jefferson, Maryland 21755</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		20c. Date <b>6/25/99</b>		20d. Location - City or Town, State <b>Rockville, Maryland</b>				
21. Signature of Funeral Service Licensee <b>Mont L. Williams</b>				22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. acute myocardial infarction.</b> Due to (or as a consequence of): <b>b. Pneumonia</b> Due to (or as a consequence of): <b>c. Atrial fibrillation.</b> Due to (or as a consequence of): <b>d. Hypertension.</b>				Approximate Interval Between Onset and Death <b>9 Days</b> <b>7 Days</b> <b>9 Days</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>dementia</b> <b>renal insufficiency.</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>V. Ganti</b>		29c. License number <b>D41162MB</b>		29d. Date signed (Month, Day, Year) <b>June 22, 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>V. Ganti 19529, Doctor Dr. Germantown MD 20874</b>										
31. Date filed (Month, Day, Year) <b>JUN 25 1999</b>		32. Registrar's Signature <b>B. Sparks</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

99 22148

Reg. No.

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) <b>William C. Warfield</b>				2. Date of Death Month <b>June</b> Day <b>21</b> Year <b>1999</b>		3. Time of Death <b>2:43PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>215-26-1257</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 24, 1927</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mount Airy</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>505 Buffalo Road</b>				10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assistant Manager</b>			16b. Kind of Business/Industry <b>Farm Supply Store</b>	
17. Father's Name (First, Middle, Last) <b>Thurman R. Warfield</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Virginia Carr</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Rachel Waters Warfield - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>505 Buffalo Road, Mount Airy, Maryland 21771</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery</b>		Date <b>6/24/99</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>
21. Signature of Funeral Service Licensee <b>Olin L. Molesworth</b>				22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
a. <b>SUDDEN DEATH</b> Due to (or as a consequence of):								<b>30 MINUTES</b>
b. <b>METASTATIC PANCREATIC CANCER</b> Due to (or as a consequence of):								<b>2 MONTHS</b>
c. _____ Due to (or as a consequence of):								
d. _____ Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Brenda G. Sparks, MD</b>			29c. License number <b>D31761</b>		29d. Date signed (Month, Day, Year) <b>6/22/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BRIAN M. O'CONNOR MD 581 W. SEVENTH ST. FREDERICK, MD 21701</b>								
31. Date filed (Month, Day, Year) <b>JUN 25 1999</b>		32. Registrar's Signature <b>Brenda G. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
(Medical Examiner)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22149

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Jean Wroten

2. Date of Death

Month Day Year  
June 26, 1999

3. Time of Death

8:45AM

4a. Facility Name (If not institution, give street and number)

9874 Old Claiborne Road

4b. City, Town, or Location of Death

Claiborne

4c. County of Death

Talbot

5. Social Security Number

214-34-8400

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 14, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Claiborne

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

9874 Old Claiborne Road

10f. Zip Code

21624

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic Worker

16b. Kind of Business/Industry

Private Homes

17. Father's Name (First, Middle, Last)

George Willey

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Wingate

19a. Informant's Name/Relationship (Type, Print)

Leonard W. Wroten Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 171 McDaniel, Maryland 21647

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dorchester Memorial Park 6/29/99 Cambridge, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.

700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Non-small Cell Lung Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 yrs. 3 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D39887

29d. Date signed (Month, Day, Year)

6/28/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David H. Smith, M.D. 29466 Pintail Drive, Easton MD 21601

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 29 1999

B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22150

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL

BEAUCHAMP

WARD

2. Date of Death

Month Day Year

June 23, 1999

3. Time of Death

1440

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

212-10-2646

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT. 20, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

DELMAR

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

101 E. DELAWARE AVE.

10f. Zip Code

19940

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

SHIRT FACTORY

17. Father's Name (First, Middle, Last)

ROLAND

CORDREY

18. Mother's Name (First, Middle, Maiden Surname)

ELLA

C.

GRAHAM

19a. Informant's Name/Relationship (Type, Print)

JEAN N. MALONEY GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RT. 1 BOX 494 DELMAR, DE 19940

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBRON CEMETERY

Date

6/28/99

20c. Location - City or Town, State

HEBRON, MARYLAND

21. Signature of Funeral Service Licensee

B. Keet P. Lynn, CFSP

22. Name and Address of Facility

BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

705 E. MAIN ST.

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Dissecting Aortic Aneurysm

Due to (or as a consequence of):

ASCVD

Due to (or as a consequence of):

Acute MI

Due to (or as a consequence of):

Infection

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

NATESAN MD

29c. License number

D47094

29d. Date signed (Month, Day, Year)

6/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr NATESAN, MD

106 MILFORD STREET, MD 21804

31. Date filed (Month, Day, Year)

JUN 25 1999

32. Registrar's Signature

B. Keet P. Lynn

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Ethel B. Ward 212-10-2644 58#

My wife and I

and our

children

are very

pleased to hear from you

and hope you are

well

and

love

you

Yours

and

our

family

and

all the family

and

and

our

children

and

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to the family

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22151

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LOUISE WILLIAMS</b>		2. Date of Death Month <b>06</b> Day <b>24</b> Year <b>99</b>		3. Time of Death <b>1130</b>
	4e. Facility Name (If not institution, give street and number) <b>205 MILDALE DRIVE</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>221-20-2790</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>04-16-18</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location <b>LAKELAND</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. State <b>FLORIDA</b>	10b. County <b>POLK</b>			
	10e. Street and Number <b>311 MIAMI ST.</b>		10f. Zip Code <b>33805</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>
	17. Father's Name (First, Middle, Last) <b>CHARLES A. WHETSTONE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ELLEN B. HAUP</b>		
	19e. Informant's Name/Relationship (Type, Print) <b>DELORES L. DAVIDSON - NIECE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>205 MILDALE DR. SALISBURY, MD 21804</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OAK HILL BURIAL PARK</b>		20c. Location - City or Town, State <b>6/29/99 LAKELAND, FLORIDA</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804</b>		
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):				
	b. Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  <b>D.M.E.</b>		29c. License number <b>D0003599</b>		29d. Date signed (Month, Day, Year) <b>06-24-99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>JUN 25 1999</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22152

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Darrell E. Williams

2. Date of Death

June 20 1999

3. Time of Death

4:10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

RT. 1 Box, 30 A. 4358 Sunset Dr.

4b. City, Town, or Location of Death

Tyaskin

4c. County of Death

Wicomico

5. Social Security Number

559-16-1195

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-19-1920

9. Birthplace (State or Foreign Country)

W. VA.

Usual Residence of Decedent

10a. State

Md.

10b. County

Wicomico

10c. City, Town or Location

Tyaskin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RT 1 BOX 30 A.

4358 Sunset Dr.

10f. Zip Code

21865

10g. Citizen of What Country?

US.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 2/1942 1966

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LT COL US AIR FORCE

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

Everett Elvin Williams

18. Mother's Name (First, Middle, Maiden Surname)

Alma Elizabeth Parsons

19a. Informant's Name/Relationship (Type, Print)

Regina M. Williams daughter 42 Horvath Dr. Ithaca, NY. 14850

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Tyaskin cemetery

Date

6-23-99

20c. Location - City or Town, State

Tyaskin, Md.

21. Signature of Funeral Service Licensee

Messick Funeral Home

M00416

22. Name and Address of Facility

Bivalve, Md 21814

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC CANCER, UNKNOWN PRIMARY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen A. Laffey MD

29c. License number

D20683

29d. Date signed (Month, Day, Year)

6/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN A. LAFFEY MD

31. Date filed (Month, Day, Year)

JUN 22 1999

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report

is devoted to a general

description of the

method

used

in the

study

and the results of the

investigation

are given in the

appendix

to the report

and the conclusions

are given in the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22153

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH

DAVIS

WARREN

2. Date of Death

Month  
JUNEDay  
19,Year  
1999

3. Time of Death

7:50 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

BERLIN NURSING &amp; REHABILITATION CENTER

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

5. Social Security Number

220-01-8794

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 5, 1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WORCESTER

10c. City, Town or Location

SHOWELL

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11628 WORCESTER HIGHWAY

10f. Zip Code

21862

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

POSTMASTER

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

PETER

W.

DAVIS

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

MAE

SMALLWOOD

19a. Informant's Name/Relationship (Type, Print)

MARY E. WILLIAMS/GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6890 SANDY RIDGE COURT, SALISBURY, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVERGREEN CEMETERY

Date

6/23/99

20c. Location - City or Town, State

BERLIN, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

23a. Name. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

046257

29d. Date signed (Month, Day, Year)

6/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9714 Heathway Drive Berlin, MD 21811

31. Date filed (Month, Day, Year)

JUN 22 1999

32. Registrar's Signature

B Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22154

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STANLEY</b>		2. Date of Death Month: <b>06</b> Day: <b>21</b> Year: <b>99</b>		3. Time of Death <b>0615</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>115-18-4820</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>03-04-26</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Salisbury</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>220 Dove St.</b>		10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>10</b> College (1-4 or 5+): <b>-</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Landscaping</b>		
	17. Father's Name (First, Middle, Last) <b>Howard Weeks</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Alice (unknown)</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Lorraine C. Weeks/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>220 Dove St., Salisbury, MD 21804</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CARCINOMA LARYNX; POST SURGERY AND RADIATION</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  <b>D.M.E.</b>					
29c. License number <b>D0003599</b>					
29d. Date signed (Month, Day, Year) <b>06-22-99</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801</b>					
31. Date filed (Month, Day, Year) <b>JUN 23 1999</b>					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

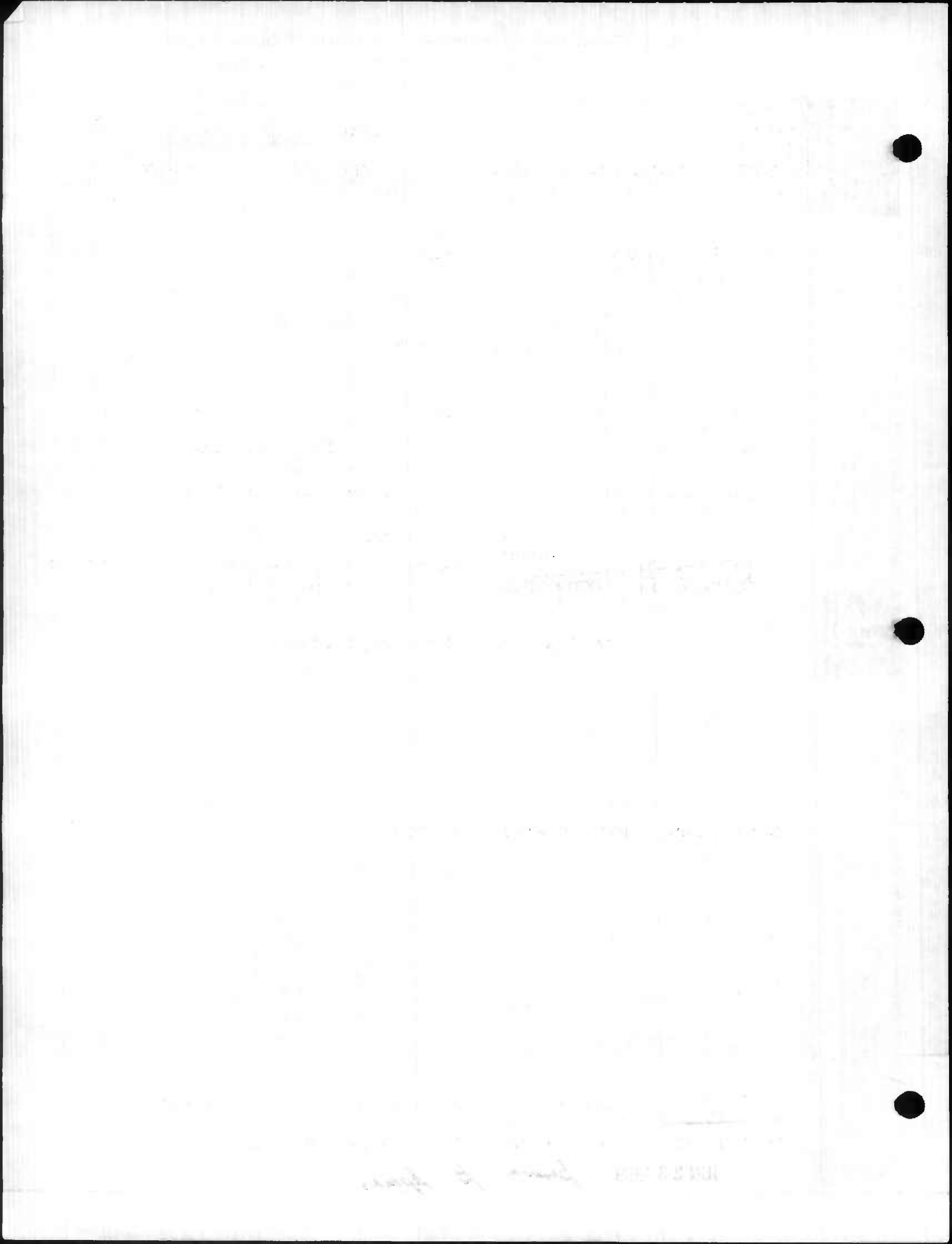
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22155

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOVONNE M. ALBERS

2. Date of Death

July 9 1999

3. Time of Death

830 PM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

234-38-1669

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 6 1925

9. Birthplace (State or Foreign Country)

W. Va

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

BALTIMORE, Md

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2509 LIST AVE

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12<sup>th</sup>College (1-4 or 5+)  
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TYPIST

16b. Kind of Business/Industry

GLEN L. MARTIN CO.

17. Father's Name (First, Middle, Last)

FAYNE KINNEY

18. Mother's Name (First, Middle, Maiden Surname)

ALTA BUNGARD

19a. Informant's Name/Relationship (Type, Print)

JOHN ALBERS / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2509 LIST AV. BALTO MD. 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLLY HILLS CEMETERY

Date

7/12/99

20c. Location - City or Town, State

BALTO. Co.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME, CHD.  
7527 HANFORD RD. BALTO. MD. 21234

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. A Septic

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Breast Cancer

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D08093

29d. Date signed (Month, Day, Year)

July 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3400 BIEHM'S LANE BALTO. MD 21213

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





99 22156

AMEND ITEM #2 PER MD. G7737-19-99 J.A.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lillian Brittle</b>				2. DATE OF DEATH MONTH <b>July</b> DAY <b>11</b> YEAR <b>1999</b>		3. TIME OF DEATH <b>3:55 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-20-4596</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 26, 1927</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Blue Point Nursing &amp; Rehab</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>	
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>5102 ARBUTUS AVENUE</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th GRADE</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DOMESTIC WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PRIVATE FAMILIES</b>			
17. FATHER'S NAME (First, Middle, Last) <b>FRANKLIN BLACK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE ROBINSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JERRY BRITTLE (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5102 ARBUTUS AVE. BALTIMORE, MD. 21215</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY 7-14-99 BALTIMORE, MARYLAND</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>		20d. DATE <b>7-14-99</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic lung cancer to brain</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>8 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure disorder, Hypertension</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Amatan H. Maqeen M.D.</b>				29c. LICENSE NUMBER <b>D 15503</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 13, 1999</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>AMATAN H MAQEEN, 501 Dolphin St, Baltimore, MD 21217</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 14 1999</b>				32. REGISTRAR'S SIGNATURE 			

BALTIMORE, MARYLAND 21215-0020

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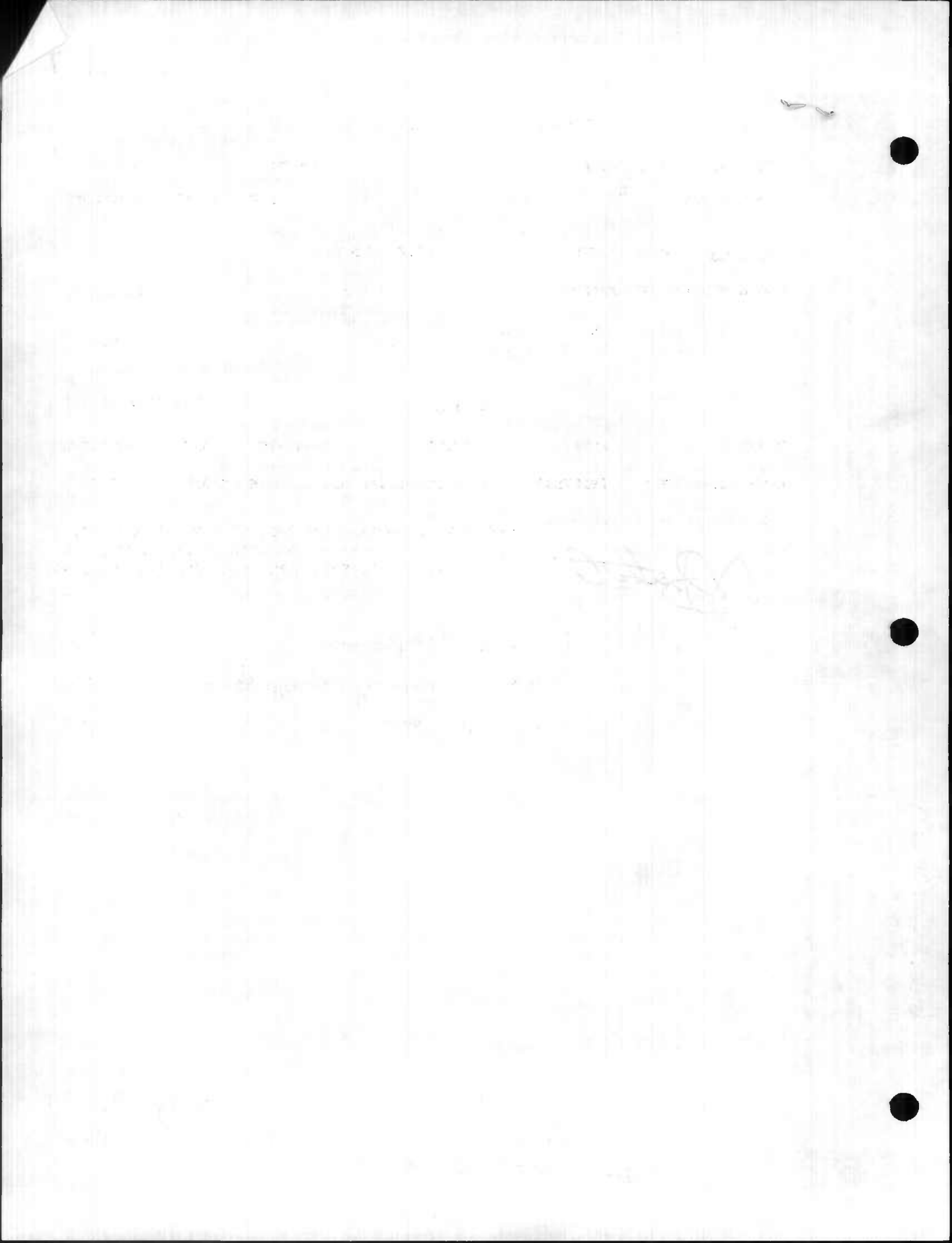
State of Maryland / Department of Health and Mental Hygiene **99 22157**  
**Certificate of Death**

Reg. No.

Physician /Medical Examiner	Decedent's Name (First, Middle, Last) <b>GEORGE EDWARD BROWN</b>				2. Date of Death Month <u>July</u> Day <u>12</u> Year <u>1999</u>		3. Time of Death <u>11:15 pm</u>
	4a. Facility Name (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>217-22-1063</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 11, 1918</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>ANNE ARUNDEL</b>	10c. City, Town or Location <b>GLEN BURNIE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>904 BROADVIEW BOULEVARD</b>			10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>UN-</b> If Yes, Give Year or Dates: <b>KNOWN</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PIPELAYER</b>		16b. Kind of Business/Industry <b>CONSTRUCTION</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>HARRY HENRY BROWN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET ANN MUSGROVE</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>RUTH STINCHCOMB (SISTER)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1106 BROADVIEW BLVD., GLEN BURNIE, MD. 21061</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK</b>		Date <b>7/16/99</b>	20c. Location - City or Town, State <b>GLEN BURNIE, MD.</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>				
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.							Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. <b>Cardiac tamponade</b> Due to (or as a consequence of):							<b>5d</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last f. <b>Severe coronary artery disease</b> Due to (or as a consequence of):							<b>years</b>
g. <b>Hypertension</b> Due to (or as a consequence of):							<b>years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dr. Linda D. Burkhardt, MD</b>		29c. License number <b>D45862</b>	29d. Date signed (Month, Day, Year) <b>July 13, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LINDA D. BURKHARDT 201 E. University Pkwy Baltimore, MD 21218</b>							
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <b>George B. Sparks</b>					

Baltimore, Maryland 21215-0020

George Brown  
 Division of Vital Records, P.O. Box 68760,



99-4031-045

KEVIN  
BRADLEY

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22158

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KEVIN B. BRADLEY				2. Date of Death Month Day Year JULY 10, 1999		3. Time of Death 7:45A.M.				
	4a. Facility Name (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO				
Funeral Director	5. Social Security Number 458-55-8785		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 19 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 23, 1980		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent										
10a. State Delaware			10b. County Kent		10c. City, Town or Location Dover			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 18 Lost Tree Ct.					10f. Zip Code 19904		10g. Citizen of What Country? United States				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) student			16b. Kind of Business/Industry N/A				
17. Father's Name (First, Middle, Last) Charles W. Bradley					18. Mother's Name (First, Middle, Maiden Surname) Grayce P. Nye						
19a. Informant's Name/Relationship (Type, Print) Charles W. Bradley/Father					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Lost Tree Ct. Dover, DE 19904						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sharon Hill Memorial Park			Date 7/15/99		20c. Location - City or Town, State Dover, Delaware			
21. Signature of Funeral Service Licensee John D. Mitchell IV					22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head and Chest Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) 7/10/99		28b. Time of Injury 0640 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Passenger in auto accident		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier John A. Locke MD			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 11, 1999			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JUL 14 1999			32. Registrar's Signature J. Aaron Locke								



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State of Maryland / Department of Health and Mental Hygiene 99 22159

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAURA E. BRADFORD</b>				2. Date of Death Month Day Year <b>July 12 1999</b>		3. Time of Death <b>2:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-24-0029</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-15-26</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2311 CROSSETT RD.</b>		10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CAFETERIA WORKER</b>		16b. Kind of Business/Industry <b>SCHOOL SYSTEM</b>				
17. Father's Name (First, Middle, Last) <b>LOUIS HOWARD, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JUANITA TAYLOR</b>				
19a. Informant's Name/Relationship (Type, Print) <b>LYNN PATTERSON/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2311 CROSSETT RD. BALTO. MD. 21237</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		20c. Date <b>7/16/99</b>		20d. Location - City or Town, State <b>BALTIMORE, MD</b>		
21. Signature of Funeral Service Licensee <b>James A. Morton</b>				22. Name and Address of Facility <b>JAMES A. MORTON &amp; SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypoxia</b> Due to (or as a consequence of): <b>b. Ischemia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>						Approximate Interval Between Onset and Death <b>10 Days</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Dawn M. Warner</b>		29c. License number <b>187252</b>		29d. Date signed (Month, Day, Year) <b>July 12, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dawn M. Warner 9000 Franklin Square Drive Baltimore, Maryland 21237</b>								
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <b>Dawn M. Warner</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Bradford, Laura E.,  
Baltimore, Maryland 21215-0020





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State of Maryland / Department of Health and Mental Hygiene 99 22160

7-13-99

ITEM #1 PER PHYNS. G773J.A. Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DEZIREE MARIE BROWN

2. Date of Death

May 23, 1999

3. Time of Death

00:26

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

Unknown

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 22, 1999

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Upperco

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

41-B Union Street

10f. Zip Code

21155

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Rhonda Brown

19a. Informant's Name/Relationship (Type, Print)

Rhonda Brown - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

41-B Union St - Upperco, Md. 21155

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Johns Hopkins Hospital 5/24/99 Baltimore, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Raymond Johnson

22. Name and Address of Facility

SHH-600 N. Wolfe St. 21287

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary Interstitial Emphysema

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to Immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Hyaline Membrane Disease

Due to (or as a consequence of):

1 day

Extreme Prematurity

Due to (or as a consequence of):

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Overwhelming Sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Scengel, MD

29c. License number

PEDIATRICIAN RES-000

29d. Date signed (Month, Day, Year)

5/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID SCENGEL, MD 600 North Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

B. Spahr

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RESEARCH REPORT

BY

JOHN EDGAR HOOVER

AND

WILLIAM L. BROWN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22161

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Damon Bolling, Sr.				2. Date of Death Month Day Year July 12, 1999		3. Time of Death 7:20AM	
	4a. Facility Name (If not institution, give street and number) 1927 Ewald Avenue				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 228-50-6064		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 30, 1938	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1927 Ewald Ave.		10f. Zip Code 21222	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1956-62	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (14 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Burner				16b. Kind of Business/Industry Steel Industry		17. Father's Name (First, Middle, Last) Grover Cleveland Bolling	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Cora Belle Neal				19a. Informant's Name/Relationship (Type, Print) Wife Mrs. Margaret A. Bolling		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1927 Ewald Ave. Dundalk, Maryland 21222	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery 7/15/1999		20c. Location - City or Town, State Suitland, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Stephanie Hester</i>				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>MD</i> 29c. License number D18487 29d. Date signed (Month, Day, Year) 7/11/99	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO THANT 6830 HOSPITAL DRIVE, BALTO, MD 21237				31. Date filed (Month, Day, Year) JUL 14 1999		32. Registrar's Signature <i>B. Apata</i>	
	31. Date filed (Month, Day, Year) JUL 14 1999				32. Registrar's Signature <i>B. Apata</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22162

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harold George Bremmer, Sr.				2. Date of Death Month Day Year July 8, 1999		3. Time of Death 1:30 PM	
	4a. Facility Name (If not institution, give street and number) 306 South Newkirk Street				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-07-8561		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 28, 1920	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore City	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 306 South Newkirk Street		10f. Zip Code 21224		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Conrail Conductor		16b. Kind of Business/Industry Railroad		17. Father's Name (First, Middle, Last) George Bremmer	
	18. Mother's Name (First, Middle, Maiden Surname) Ida May Brustarr		19a. Informant's Name/Relationship (Type, Print) Wife Mrs. Stella Frances Bremmer		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 South Newkirk St. Baltimore, Maryland 21224		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park 7/12/1999		20c. Location - City or Town, State Dorsey, Maryland		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adenocarcinoma of the Prostate, hormone refractory and metastatic		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
State Registrar	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
	29c. License number D42979		29d. Date signed (Month, Day, Year) July 9, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street Baltimore MD 21287		31. Date filed (Month, Day, Year) JUL 14 1999	
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



217 24 8240

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22163

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

RICHARD

BECKER

2. Date of Death

Month Day Year  
JULY 11 1999

3. Time of Death

19:26

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-24-8240

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07/19/1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5507 Remmell Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sheet Metal Mechanic

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Henry Becker

18. Mother's Name (First, Middle, Maiden Surname)

Teresa Buettner

19a. Informant's Name/Relationship (Type, Print)

Mrs. Sandra Climaco/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7220 Larkspur Drive, Peoria, Arizona 85381

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

07/15/99 Baltimore, Maryland

21. Signature of Funeral Service Licensee Christina L. David

Christina L. David

22. Name and Address of Facility Leonard J. Ruck, Inc.

5305 Harford Road, Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

COPD

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P 11390

29d. Date signed (Month, Day, Year)

JULY 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NONA SABRA, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239.

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22164

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>GUSTAV BIRKELIEN</u>				2. Date of Death Month <u>JULY</u> Day <u>12</u> Year <u>1999</u>		3. Time of Death <u>6:06 AM</u>	
	4e. Facility Name (If not institution, give street and number) <u>GOOD SAMARITAN HOSPITAL</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>NA</u>	
Funeral Director	5. Social Security Number <u>214-14-4663</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>76</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>July 20, 1922</u>	
	9. Birthplace (State or Foreign Country) <u>Md.</u>		10a. State <u>Md</u>		10b. County <u>NA</u>		10c. City, Town or Location <u>BALTIMORE, Md</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <u>1</u> Yes <u>2</u> No		10e. Street and Number <u>1818 E. BELVEDERE AV.</u>		10f. Zip Code <u>21239</u>		10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: <u>WWII</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4or 5+) <u>NA</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>CARPENTER</u>		16b. Kind of Business/Industry <u>CONST. CO.</u>			
	17. Father's Name (First, Middle, Last) <u>GUSTAV BIRKELEIN</u>				16. Mother's Name (First, Middle, Maiden Surname) <u>IDA SIMPSON</u>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>DORA BIRKELEIN / WIFE</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1818 E. BELVEDERE AV. BALTO MD 21239</u>			
	20e. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GREENMOUNT Com.</u>		Date <u>7/15/99</u>		20c. Location - City or Town, State <u>BALTIMORE</u>	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <u>Hartley Miller</u>				22. Name and Address of Facility <u>HARTLEY MILLER FUNERAL HOME, CHTO - 7527 HARFORD RD. BALTO MD 21234</u>			
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumothorax</u> Due to (or as a consequence of): b. <u>lung nodules</u> Due to (or as a consequence of): c. <u>WPD</u> Due to (or as a consequence of): d. <u>CAD.</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown			
	24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No				24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)					
	27. Manner of Death <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No	
State Registrar	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <u>1</u> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>P11390</u>		29d. Date signed (Month, Day, Year) <u>JULY 12, 1999</u>	
41410	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>SPONA SAGRA, 5601 COLT AVEN BLVD, BALTIMORE, MD 21239.</u>							
	31. Date filed (Month, Day, Year) <u>JUL 14 1999</u>				32. Registrar's Signature <u>[Signature]</u>			



WRC  
99-4067-510  
DARIUS  
COX

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22165

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

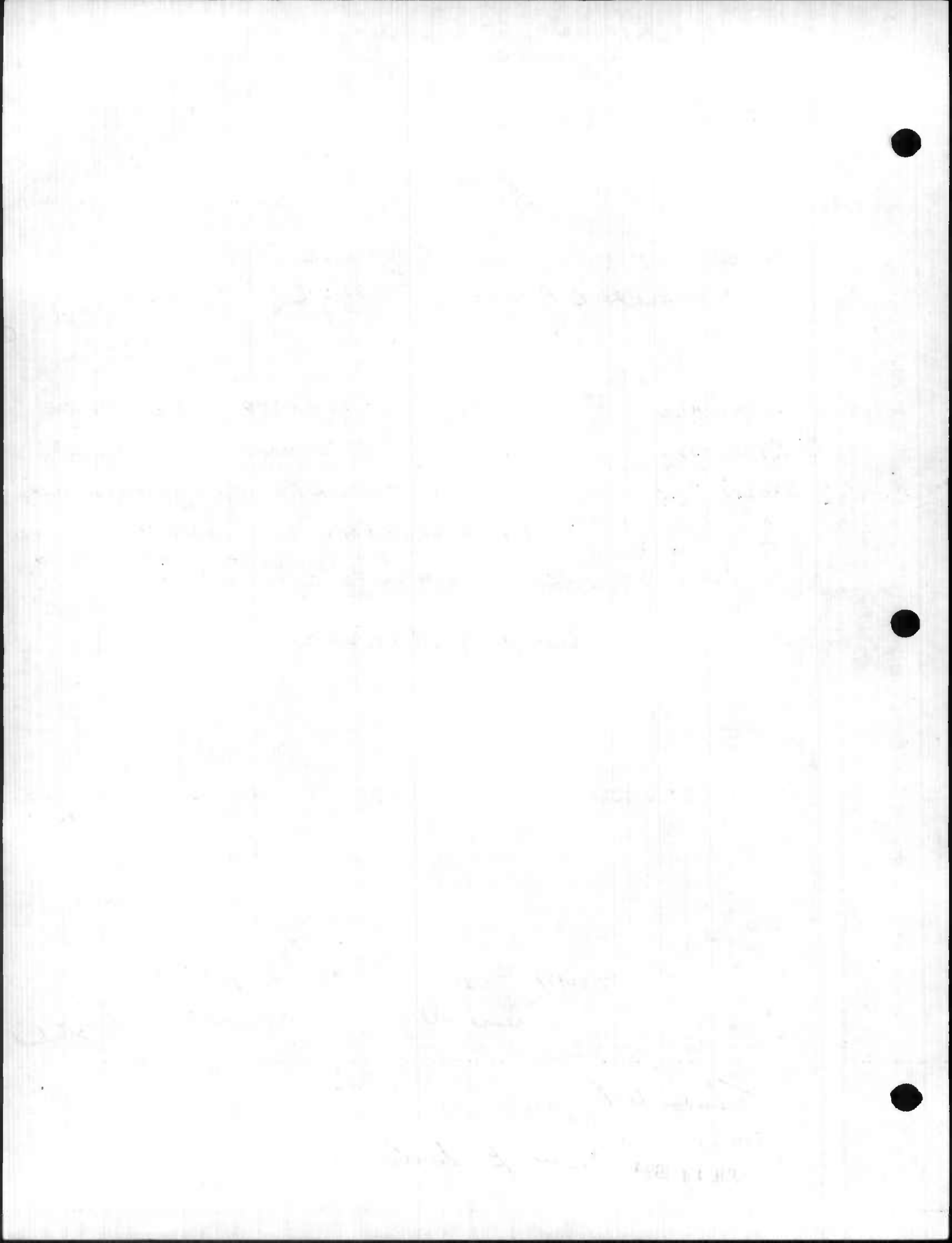
Physician  
/Medical  
Examiner

Funeral  
Director

State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>DARIUS CHADWICK COX</b>				2. Date of Death Month Day Year <b>JULY 12, 1999</b>		3. Time of Death <b>9:09 PM.</b>	
4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>120-98-7442</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>31</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MARCH 17, 1968</b>	
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>							
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2214 WALBROOK AVENUE</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th GRADE</b>		College (14 or 5+) <b>ASSISTANT MANAGER</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SHOE STORE</b>		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) <b>ELWOOD COX</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EVELYN WEST</b>			
19a. Informant's Name/Relationship (Type, Print) <b>EVELYN COX (MOTHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2214 WALBROOK AVENUE, BALTIMORE MD. 21216</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		Date <b>7-17-99</b>		20c. Location - City or Town, State <b>WOODLAWN, MARYLAND</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVENUE, BALTO. MD. 21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple Gunshot Wounds</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>7/12/99</b>		28b. Time of Injury <b>2030</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred <b>subject shot</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>near alley</b>					
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2406 East Monument Street Baltimore</b>							
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THE SONS OF MARY 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>				32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22166

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Brenda Lee Coleman</b>				2. Date of Death Month <b>July</b> Day <b>5</b> Year <b>1999</b>		3. Time of Death <b>1215</b>	
	4a. Facility Name (If not institution, give street and number) <b>Deaton Nursing Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-68-1561</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 12, 1961</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>N/A</b>	
10a. Street and Number <b>3509 Liberty Heights Ave.</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>African American</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Factory Worker</b>		16b. Kind of Business/Industry <b>Md. Cup Co.</b>				
17. Father's Name (First, Middle, Last) <b>Benjamin Coleman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Dorsey</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ms. Cynthia Coleman (sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3509 Liberty Heights Ave. Balto, Md. 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>unk Sacred Heart of Jesus</b>		20c. Location - City or Town, State <b>7/16/99 unk Dundalk, Md. unk</b>				
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>B Cell Lymphoma - Brain</b> Due to (or as a consequence of): <b>Acquired Immunodeficiency Syndrome?</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>4 mos.</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Carla S. Alexander MD</b>		29c. License number <b>D27057</b>		29d. Date signed (Month, Day, Year) <b>7/6/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CARLA S. ALEXANDER, MD DEATON SPECIALTY HOSPITAL 611 S Charles Balto</b>								
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <b>Anna B. Sparks</b> <b>21230 Md</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

KENNETH JOSEPH CARMAN

AMEND: #23 PART I, 27 PER MEO G773 7-28-99 WR.

99 22167

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kenneth J. Carman</b>				2. Date of Death Month Day Year <b>JULY 12, 1999</b>				3. Time of Death <b>0700 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>4407 MEADOWCLIFF ROAD</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>216 66 8626</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>39</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>11-6-1959</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1792 Joan Ave</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>		16b. Kind of Business/Industry <b>Aerospace</b>		17. Father's Name (First, Middle, Last) <b>William L. Carman</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anne Dannenmann</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Charles Carman/ Brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1792 Joan Ave Baltimore, MD 21234</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		20c. Location - City or Town, State <b>Baltimore</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore MD 21286</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>FATTY LIVER</b> Due to (or as a consequence of):  b. <b>ALCOHOLISM</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYLAND P. KOEN</b>		31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature 						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22168

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Corine Cole</u>				2. Date of Death Month Day Year <u>JUL 8 1999</u>				3. Time of Death <u>1709</u>		
	4a. Facility Name (If not institution, give street and number) <u>Sinar Hospital of Baltimore</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>NA</u>		
Funeral Director	5. Social Security Number <u>213-28-7739</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>82</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>04-16-17</u>		9. Birthplace (State or Foreign Country) <u>NC</u>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <u>MD</u>		10b. County <u>NA</u>		10c. City, Town or Location <u>Baltimore</u>				10d. Inside City Limits <u>1</u> Yes <u>2</u> No		
	10e. Street and Number <u>3928 Clarineth Road</u>				10f. Zip Code <u>21215</u>				10g. Citizen of What Country? <u>USA</u>		
	11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5th Grade</u> College (1-4 or 5+) <u>NA</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Presser</u>				16b. Kind of Business/Industry <u>Central Laundry</u>		
	17. Father's Name (First, Middle, Last) <u>Richard Dukes</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Lorriane Laury</u>						
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) <u>Betty Johnson</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3928 Clarineth Road Baltimore, Maryland 21215</u>						
	20a. Method of Disposition <u>X</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Arlington Nat'l Cem.</u>				20c. Location - City or Town, State <u>07-19-99 Arlington, VA.</u>		
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Baltimore, Maryland 21202</u> <u>WM.C.March FH 1101 E. North Avenue</u>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Cerebrovascular Accident</u> Due to (or as a consequence of): <u>b.</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
	23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown										
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia - Alzheimers</u>										
	24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown										
	24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No										
	25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No				26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)						
	27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <u>1</u> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>H43157</u>				29d. Date signed (Month, Day, Year) <u>7/10/99</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>2435 W. Belvedere, Baltimore MD 21215</u>											
31. Date filed (Month, Day, Year) <u>JUL 14 1999</u>				32. Registrar's Signature <u>[Signature]</u>							

Patient known as: Corine Cole  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22169  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Annie Cagle</b>				2. Date of Death Month <b>July</b> Day <b>9</b> Year <b>1999</b>		3. Time of Death <b>10:15a</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital 2401 W. Belvedere Baltimore</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-10-7434</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>09-06-15</b>	
	9. Birthplace (State or Foreign Country) <b>BLACK</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3801 GWYNN OAK AVE</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEKEEPING</b>		16b. Kind of Business/Industry <b>SCHOOL SYSTEM</b>				
17. Father's Name (First, Middle, Last) <b>JOHN CAGLE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE ROSS</b>		19a. Informant's Name/Relationship (Type, Print) <b>JOYCE FULLER, NEICE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3801 GWYNN OAK AVE, BALTO. MD 21207</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEM. PARK</b>		20c. Location - City or Town, State <b>7-15-99 BALTO. MD</b>				
21. Signature of Funeral Service Licensee <i>Willie E. H.</i>		22. Name and Address of Facility <b>HOWELL FUNERAL HOME 4600 LIBERTY HIGHTS AVE. BALTO. MD 21207</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. pneumonia</b> Due to (or as a consequence of): <b>b. renal failure</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>dementia</b>		Approximate Interval Between Onset and Death <b>one week</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>dementia</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Frances G. Williams, MD</b>		29c. License number <b>P10441</b>		29d. Date signed (Month, Day, Year) <b>July 9, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frances E. Williams, MD Sinai Hospital 2401 W. Belvedere Baltimore, MD</b>		31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <i>G. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

99 22170

ITEMS: #23 PART 1, 27, 28A-F PER MEO G773 7-19-99 WR. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wayne Herbert Curran</b>				2. Date of Death Month Day Year <b>July 07, 1999</b>		3. Time of Death <b>11:08 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>2920 Pennsylvania Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore Highlands</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>216 42 1292</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		6. Under 1 Year Months Days <b>Nov. 18, 1944</b>	
	6. Under 24 Hrs. Hours Min. <b>Nov. 18, 1944</b>		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2920 Pennsylvania Avenue</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>U.S.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b> <b>2 years</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Printer</b>		16b. Kind of Business/Industry <b>Printing Company</b>		
17. Father's Name (First, Middle, Last) <b>Edward Curran</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Doris Stevens</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Peggy Curran / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2816 Vermont Avenue Baltimore, Maryland 21227</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>7/13/99</b>		20c. Location - City or Town, State <b>Towson, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Donna M. Branciouski</i>				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>NARCOTIC INTOXICATION</b> Immediate Cause (Final disease or condition resulting in death) a. <i>Antisocial Personality Disorder</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <i>limited</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) <b>Found: July 7, 1999</b>		28b. Time of Injury <b>Found: 10:30 A M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred <b>UNKNOWN</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2920 PENNSYLVANIA AVE, BALTIMORE, MD</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Theodore M. King</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>July 08, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>			32. Registrar's Signature <i>Anna B. Sparks</i>					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22171

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN DAS</b>				2. Date of Death Month <b>July</b> Day <b>13</b> Year <b>1999</b>				3. Time of Death <b>0315</b>	
	4a. Facility Name (If not institution, give street and number) <b>Lorien Riverside Nursing Home</b>				4b. City, Town, or Location of Death <b>Belcamp</b>				4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>216-03-1907</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 9, 1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>MD.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Jarrettsville</b>	
10a. Street and Number <b>1416 Dalewood Drive</b>		10f. Zip Code <b>21084</b>		10g. Citizen of What Country? <b>U.S.A.</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>		16b. Kind of Business/Industry <b>Factory</b>						
17. Father's Name (First, Middle, Last) <b>Julian Piorunski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Standera</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Lorraine Kreseski (Niece)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1416 Dalewood Drive, Jarrettsville, MD. 21084</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		Date <b>7/14/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ALZHEIMER'S DISEASE</b>  Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>5 YEARS</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>				24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>Andrew Nowakowski MD</b>				29c. License number <b>D08096</b>		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>ANDREW NOWAKOWSKI M.D. 65 N. MAIN ST. BEL AIR, MD 21014</b>				31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature 				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

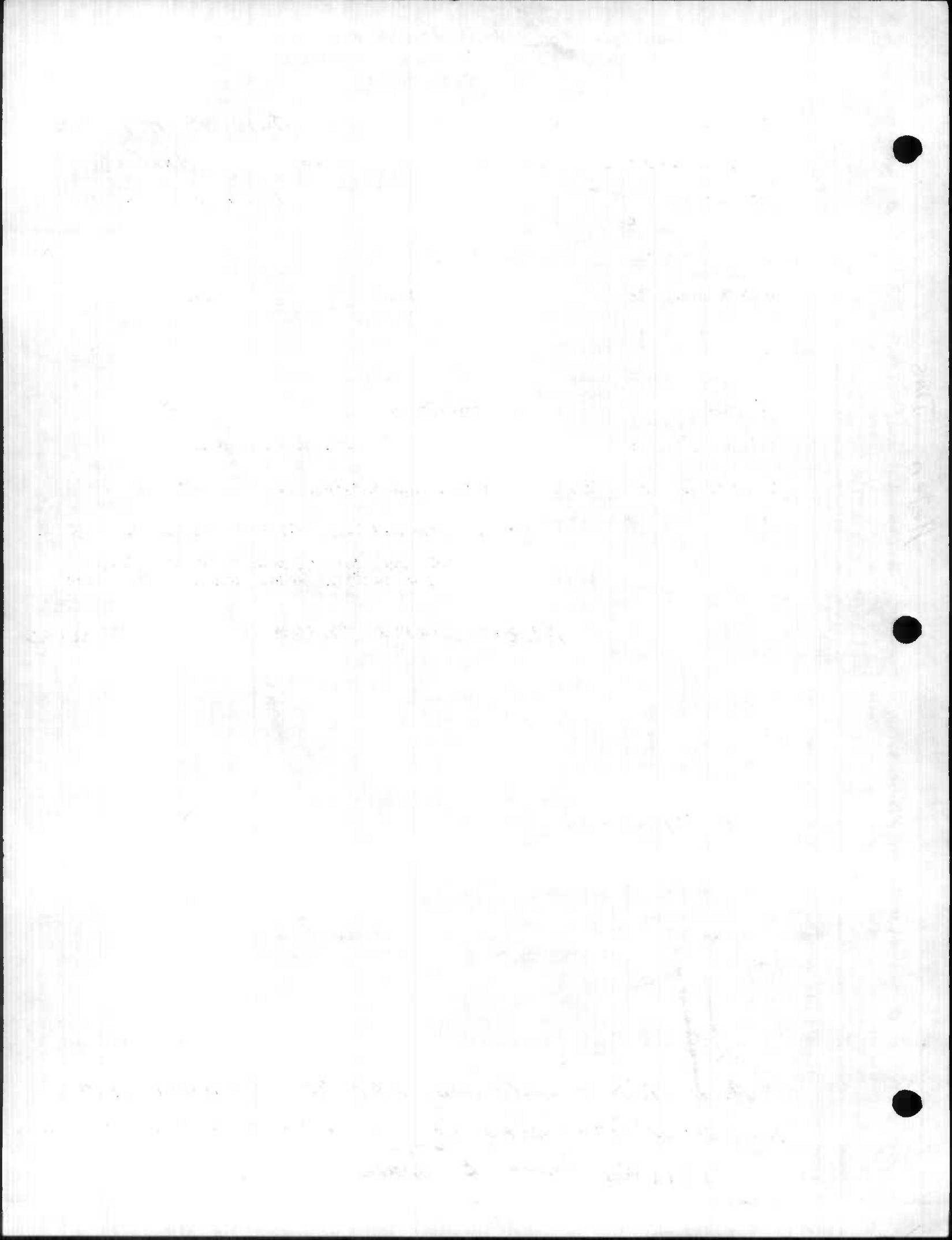
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22172

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CAROLYN EDWARDS</b>				2. Date of Death Month Day Year <b>JULY 08 1999</b>		3. Time of Death <b>3:45P</b>	
	4a. Facility Name (If not institution, give street and number) <b>LIBERTY MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NIA</b>	
Funeral Director	5. Social Security Number <b>217-52-7039</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 17, 1948</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>NIA</b>	10c. City, Town or Location <b>BALTIMORE CITY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>3415 GWYNNS FALLS PKY APT 6</b>			10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH GRADE</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLINICAL FOSTER MOTHER</b>		16b. Kind of Business/Industry <b>FOSTER CARE</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>WILLIAM BURWELL</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE COZART</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>ANNIE WILSON (MOTHER)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1014 PENNSYLVANIA AVE. BALTIMORE, MD. 21201</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		Date <b>07-13-99</b>		20c. Location - City or Town, State <b>LANSDOWNE, MD.</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIAC ARRHYTHMIAS</b>							<b>1 hr</b>
	Due to (or as a consequence of): <b>b. SYMPTOMATIC ANAEMIA</b>							<b>UNKNOWN</b>
	Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c. ACUTE RENAL FAILURE</b>							<b>"</b>
Due to (or as a consequence of): <b>d. MORBID OBESITY</b>							<b>"</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Hx. HYPERTENSION</b> <b>Hx. UTERINE BLEEDING</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 23300</b>		29d. Date signed (Month, Day, Year) <b>JULY 08 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SUDHIR D. PATEL 2600 LIBERTY RD. BALLO MD. 21215</b>								
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22173

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Marie Ellison

2. Date of Death

Month Day Year  
July 10 1999

3. Time of Death

8:51 P.M.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

213 20 3508

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 7, 1919

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5344 Patrick Henry Drive

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Garment

17. Father's Name (First, Middle, Last)

John Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Osie Allen

19a. Informant's Name/Relationship (Type, Print)

Lloyd Ellison / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

193 - 12th Street Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Thompson Cemetery

Date

7/15/99

20c. Location - City or Town, State

Long Branch, W.V.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Lung Cancer

Due to (or as a consequence of):

right pleural effusion

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

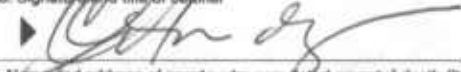
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D42820

29d. Date signed (Month, Day, Year)

July 12, 1999

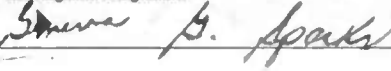
30. Name and address of person who completed cause of death (Part 23a) (Type, Print)

Christopher deBorga MD 3708 Mountain Rd. Pasadena Md. 21122

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, R



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22174

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia Flaherty</b>				2. Date of Death Month <b>July</b> Day <b>11</b> Year <b>1999</b>		3. Time of Death <b>8:50 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>4129 Potter Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219 50 4537</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 3, 1936</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>112 South Monroe Street</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Archie Watkins</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Virgie Everhart</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Anna Shadle / Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4129 Potter Street Baltimore, Maryland 21229</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Anna J. Zmierski</i>		22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>		23a. Part I. Enter the disease, or combination that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lung Cancer</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Approximate Interval Between Onset and Death <b>5 mo.</b>	
23d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Sister's Home</b>	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Wm C. Waterfield</i>		29c. License number <b>024356</b>	
29d. Date signed (Month, Day, Year) <b>July 12, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wm C. Waterfield St. Agnes Comm. Center 900 Catho Rd Balt Md 21229</b>		31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <i>B. Sparks</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22175

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George J. Floyd JR.</b>				2. Date of Death Month <b>7</b> Day <b>10</b> Year <b>99</b>		3. Time of Death <b>4:48</b>	
	4a. Family Name (If not institution, give street and number) <b>Bon Secure</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>220-36-9152</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth Month <b>7</b> Day <b>30</b> Year <b>1942</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>MD</b>		10e. State <b>MD</b>		10b. County <b>NA</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10f. Zip Code <b>21217</b>	
	10g. Citizen of What Country? <b>USA</b>				10h. Street and Number <b>1125 McKean Ave</b>		10i. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1967-1969</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>African American</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (13 or 5+) <b>0</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRINTER</b>		16b. Kind of Business/Industry <b>PRINTING</b>		17. Father's Name (First, Middle, Last) <b>George J. Floyd Sr.</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Geraldine Cooper</b>				19. Informant's Name/Relationship (Type, Print) <b>Roxanne Prettyman</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1125 McKean Ave. Baltimore, MD 21217</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metco Crematory</b>		20c. Date <b>7/13/99</b>		20d. Location - City or Town, State <b>Catonsville, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Robert P. W. J. Funeral Hm PA 638 N. Gilmer St. Baltimore, MD</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. PULMONARY EMBOLISM</b> Due to (or as a consequence of): <b>b. DEEP VEIN THROMBOSIS</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b> <b>SEIZURE DISORDER</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 				29c. License number <b>D24100</b>		29d. Date signed (Month, Day, Year) <b>07-11-99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MADURA L. PRABHAKAR M.D. 2115 OLD FOREMS ROAD</b>								
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature 						





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22176

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY LILLIAN GWIAZDA

2. Date of Death  
Month Day Year

July 12 1999

3. Time of Death

5:50 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health of Bel Air

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

215-07-0067

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 6, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppatowne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

334 Oakway Court

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teachers Aid

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Wade Wheelley

18. Mother's Name (First, Middle, Maiden Surname)

Maude (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Leo J. Gwiazda (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

334 Oakway Court, Joppatowne, MD. 21085

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

7/13/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonitis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

couple of days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Dementia (Alzheimer's Type)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MANUEL M. LAZARUS, MD

DIST 83

July 12, 1999

8 Law Street, Aberdeen Maryland 21001

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

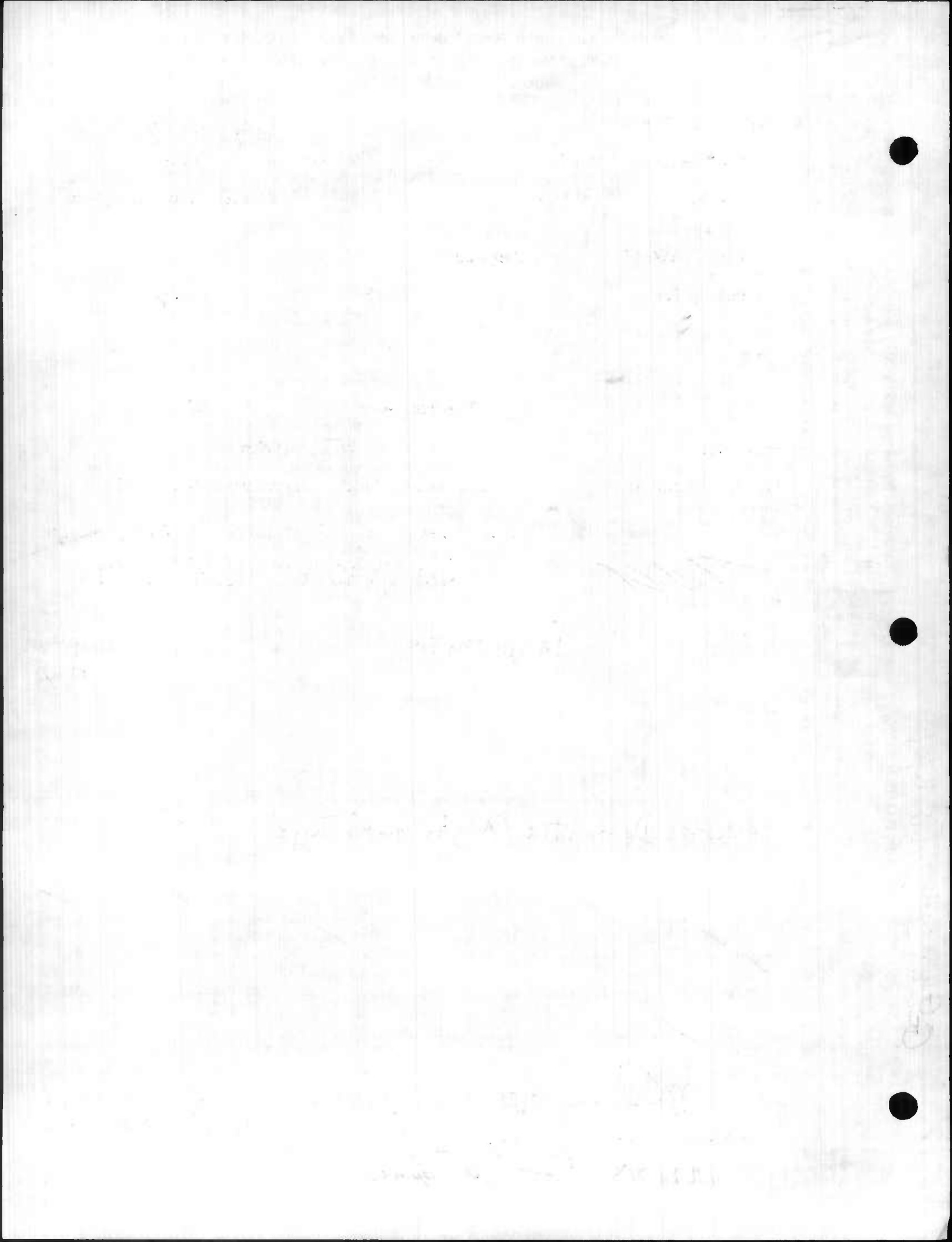
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22177

## Certificate of Death

Reg. No.

AMENDED ITEM #19a PER FH G773 7/14/99 AH

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Eleonora Gantautas

2. Date of Death  
Month Day Year  
July 10, 19993. Time of Death  
5:30 p.m.

4a. Facility Name (If not institution, give street and number)

Lorien Nursing &amp; Rehabilitation

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

045-26-8755

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02/19/1900

9. Birthplace (State or Foreign Country)

Lithuania

Usual Residence of Decedent

10a. State

Md

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9457 Tiller Drive

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Edward SAKALAUSKAS/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9457 Tiller Drive, Ellicott City, Md 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Michael Cemetery

Date

7/14/99

20c. Location - City or Town, State

Stratford, CT

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling-Ashton-Schwab

736 Edmondson Ave. Catonsville, Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Lymphoma  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

29d. License number

D40413

29e. Date signed (Month, Day, Year)

07/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marguerite Summers, MD 2 Knoll N Drive Columbia, MD 20143

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

G. Spauld

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22178

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille E. Gambos

2. Date of Death

Month  
July

Day  
9

Year  
1999

3. Time of Death

4:30 P.M.

4a. Facility Name (If not institution, give street and number)

Mariner Health of Glen Burnie

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

240 30 2118

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 22, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

316 W. Arundel Road

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Louis Stein

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Gebhardt

19a. Informant's Name/Relationship (Type, Print)

Joseph Woodson / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

316 W. Arundel Road Baltimore, Maryland 21225

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

7/13/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*Jerome Znamianski*

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cerebro Vascular accident*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*10 days*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Pneumonia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Daljit Singh Sidhu MD*

29c. License number

D 38958

29d. Date signed (Month, Day, Year)

7/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Daljit Singh Sidhu 1413 Annapolis Road #106 Odenton MD 21113*

31. Date Used (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Gambos, Lucille 4:30pm  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22179

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DIANE ELIZABETH HERRON</b>				2. Date of Death Month Day Year <b>July 11 1999</b>		3. Time of Death <b>0728</b>	
	4a. Facility Name (If not institution, give street and number) <b>ER FALLSTON GEN HOSPITAL</b>				4b. City, Town, or Location of Death <b>FALLSTON</b>		4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>213-66-6214</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>45</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 27, 1954</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Edgewood</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>674 Yorkshire Drive</b>		10f. Zip Code <b>21040</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b>		16. Kind of Business/Industry <b>Federal Government</b>		17. Father's Name (First, Middle, Last) <b>Matthew J. Kahl</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Rose C. Hoey</b>	
	19a. Informant's Name/Relationship (Type, Print) <b>George A. Herron (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>674 Yorkshire Drive, Edgewood, MD. 21040</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>	
Physician /Medical Examiner	20c. Date <b>7/15/99</b>		20d. Location - City or Town, State <b>Bel Air, MD.</b>		21. Signature of Funeral Service Licensee <b>Mark T. [Signature]</b>		22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC CANCER</b> Due to (or as a consequence of): <b>b. CARCINOMA LUNG</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature] DME OCMF</b>	
State Registrar	29c. License number		29d. Date signed (Month, Day, Year) <b>JULY 11 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GRABSTU 218 FALLON AVE BELAIR MD 21014</b>			
	31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <b>[Signature] B. Sparks</b>					







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22180

AMEND ITEM#2 PER PHYNS. G773 7-14-99 J.A. **Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>CHARLES HIGH</b>		2. Date of Death Month: <b>JULY</b> Day: <b>11</b> Year: <b>1999</b>		3. Time of Death <b>2120</b>
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
<b>Funeral Director</b>	5. Social Security Number <b>214-50-2979</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) <b>February 3, 1948</b>				
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>	
10e. Street and Number <b>1415 Gordon Dr.</b>				10f. Zip Code <b>21061</b>	
10g. Citizen of What Country? <b>United States</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>12</b> College (14 or 5+):			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Garage</b>
17. Father's Name (First, Middle, Last) <b>Charles Wilbur High</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Kathryn McCormick</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Dina Warzyniak/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3832 Brooklyn Ave Baltimore, MD 21225</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Cemetery</b>		20c. Location - City or Town, State <b>7-13-99 Baltimore, MD</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) s. <b>METASTATIC ESOPHAGEAL CARCINOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 			29c. License number <b>D0052122</b>		29d. Date signed (Month, Day, Year) <b>JULY 11 1999</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P. JACKSON BOOTH, 600 N. WOLFE STREET, BALTIMORE, MD 21287</b>					
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22181

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAURETTA HIGGINSON

2. Date of Death

Month Day Year  
07 12 99

3. Time of Death

7:00 pm

4a. Facility Name (If not institution, give street and number)

3 Bristol Hill Court Apt. A3

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

090 01 5105

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11/01/02

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 Bristol Hill Ct., Apt. A3

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)  
(Unknown)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Dress Maker

16b. Kind of Business/Industry

Tailoring

17. Father's Name (First, Middle, Last)

(Unknown)

Stewart

18. Mother's Name (First, Middle, Maiden Surname)

Elmira

(Unknown)

19e. Informant's Name/Relationship (Type, Print)

Marilyn Gwill / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Bristol Hill Court, Apt. A3, Baltimore, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

July 15, 1999

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Funeral Options, D. Seth Minso

6416 Frederick Rd., Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Stroke

Due to (or as a consequence of):

b.

Atrial Fibrillation

Due to (or as a consequence of):

c.

Hypertension

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

4 weeks

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician:2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

024781

29d. Date signed (Month, Day, Year)

7/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES R. GRABER JR 1001 PINE HEIGHTS AVE, 5300, BALTIMORE MD 21215

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22182

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND

R.

HARRIS

2. Date of Death

July

Day

10

Year

1999

3. Time of Death

00:32

4a. Facility Name (If not institution, give street and number)

CHURCH HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

234-44-1987

6. Sex

M

7. Age (In yrs. last birthday)

69

8. Date of Birth (Month, Day, Year)

NOV. 6, 1929

9. Birthplace (State or Foreign Country)

W. VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1111 S. ROBINSON ST.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

GENERAL MOTORS

17. Father's Name (First, Middle, Last)

ALBERT HARRIS

18. Mother's Name (First, Middle, Maiden Surname)

ELLA A. MCCOY

19a. Informant's Name/Relationship (Type, Print)

RUBY KOLB

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1111 S. ROBINSON ST. BALTO. MD. 21224

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LITTLE KANAHA M.P.

Date

JULY 16

20c. Location - City or Town, State

BRAXTON CO., W. VA.

21. Signature of Funeral Service licensee

Thomas J. Skush Jr.

22. Name and Address of Facility

HOFFMAN SKAADA 3218 HUDSON ST. BALTO. MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EDEMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. J. Helou M.D.

29c. License number

D17695

29d. Date signed (Month, Day, Year)

July 10th, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M.D. CHURCH HOSPITAL, 100 N. BROADWAY, BALTIMORE MD 21231

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

Benjamin P. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be submitted with the completed certificate to the Department of Health and Mental Hygiene.  
Important: If item 23a is marked other than "natural", or item 23b is marked other than "yes", the Medical Examiner must be notified at once.

5010

1944

1944

RECEIVED  
JAN 10 1944

1944

1944

1944



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22183

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARRY BOY HARRIS				2. Date of Death Month Day Year 6 - 14 - 99 27		3. Time of Death 9:40 PM	
	4a. Facility Name (If not institution, give street and number) MERCY MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death MD 21202	
Funeral Director	5. Social Security Number NONE		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs.		8. Date of Birth (Month, Day, Year)	
	Usual Residence of Decedent		10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1109 N. CARROLTON AVE.		10f. Zip Code 21217		10g. Citizen of What Country? U.S.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INFANT		16b. Kind of Business/Industry INFANT				
17. Father's Name (First, Middle, Last) YOUAMAN FULLARD				18. Mother's Name (First, Middle, Maiden Summa) KIEONNA LINDELL HARRIS				
19a. Informant's Name/Relationship (Type, Print) MERCY MED, RECORDS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION		Data 6/19/99		20c. Location - City or Town, State LANSDOWN, MD.		
21. Signature of Funeral Service Licensee ALBERT P. WYLIE				22. Name and Address of Facility WYLIE F.H. 638 N. GILMORE STREET				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PREMATURITY Due to (or as a consequence of): b. PREMATURE LABOR Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier William R. Hobbs M.D.				29c. License number D23215		29d. Date signed (Month, Day, Year) 6/14/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM R. HOBBS M.D. - MERCY MEDICAL CTR								
31. Date filed (Month, Day, Year) JUL 14 1999				32. Registrar's Signature B. B. B.				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Handwritten signature and date: 10-1-1966



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22184

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Thomas Hance, Sr.</b>				2. Date of Death Month Day Year <b>July 10, 1999</b>		3. Time of Death <b>6:28 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>2701 St. Lo Drive</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>212-78-3253</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>35</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>05-03-64</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1726 Darley Avenue</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Helper</b>		16b. Kind of Business/Industry <b>Sanitation Baltimore City Dept</b>		17. Father's Name (First, Middle, Last) <b>Thomas Nivens</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Maria Hance</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Maria N. Stephens</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1726 Darley Avenue Baltimore, Maryland 21213</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk. Cem.</b>		20c. Location - City or Town, State <b>07-16-99 Arbutus, MD</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Multiple Injuries</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
23d. Immediate Cause (Final disease or condition resulting in death) <b>Multiple Injuries</b>		23e. Due to (or as a consequence of): <b>Subicor fell from height</b>		23f. Due to (or as a consequence of):		23g. Due to (or as a consequence of):		23h. Due to (or as a consequence of):	
23i. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23j. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		23k. Location (Street and Number or Rural Route Number, City or Town, State) <b>2701 St. Lo Drive</b>		23l. Date of Injury (Month, Day, Year) <b>Found 7/10/99</b>		23m. Time of Injury <b>0635</b>	
23n. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		23o. Date of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Recreation Center</b>		23p. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23q. Describe how injury occurred <b>Subicor fell from height</b>		23r. License number <b>O.C.M.E.</b>	
23s. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		23t. Signature and title of certifier <i>[Signature]</i>		23u. Date signed (Month, Day, Year) <b>July 10, 1999</b>		23v. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>		23w. Date filed (Month, Day, Year) <b>JUL 14 1999</b>	
23x. Registrar's Signature <i>[Signature]</i>		23y. Date of Death (Month, Day, Year) <b>July 10, 1999</b>		23z. Registrar's Signature <i>[Signature]</i>		23aa. Date of Death (Month, Day, Year) <b>July 10, 1999</b>		23ab. Registrar's Signature <i>[Signature]</i>	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22185

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Hattie Bell Henry</b>				2. Date of Death Month <b>JULY</b> Day <b>10</b> Year <b>1999</b>		3. Time of Death <b>0830</b>	
4a. Facility Name (If not institution, give street and number) <b>Stella Maris Hospice @ Mercy</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
5. Social Security Number <b>216-76-2413</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>09-01-61</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1603 McKean Avenue</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Parent Liason</b>		16b. Kind of Business/Industry <b>Robert Poole Middle</b>	
17. Father's Name (First, Middle, Last) <b>J. C. Henry</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Rankin</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Emma Rankin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21244</b> <b>3031 Mayfield Avenue Baltimore, Maryland</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Kings Mem. Pk. Cem.</b>		Date <b>07-15-99</b>		20c. Location - City or Town, State <b>Randallstown, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>AIDS</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>							Approximate Interval Between Onset and Death <b>unknown</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Stella Maris At Mercy hospice</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D40854</b>		29d. Date signed (Month, Day, Year) <b>7/10/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Rosenberg 301 St Paul Pl Baltimore, MD 21202</b>							
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

HENRY, HATTIE




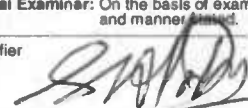
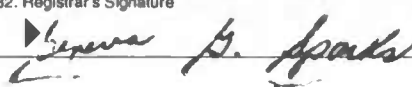
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22186

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL E. JENKINS</b>				2. Date of Death Month <b>JULY</b> Day <b>11</b> Year <b>1999</b>		3. Time of Death <b>12:40 P.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Liberty Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>217-09-0451</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>08-03-17</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent									
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
10e. Street and Number <b>501 East Preston Street Apt#719</b>				10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th Grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>various trades</b>			
17. Father's Name (First, Middle, Last) <b>George Jenkins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Jenkins</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Jerome Jenkins</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21213</b> <b>2837 Mayfield Avenue Baltimore, Maryland</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem. 07-16-99 Owings Mills,</b>		20c. Location - City or Town, State <b>MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)									
a. <b>ASPIRATION PNEUMONIA</b> <span style="float: right;">Approximate Interval Between Onset and Death <b>3 hrs</b></span>									
Due to (or as a consequence of):									
b. <b>ARTERIOSCLEROTIC HEART DISEASE</b> <span style="float: right;"><b>UNKNOWN</b></span>									
Due to (or as a consequence of):									
c. <b>END STAGE RENAL DISEASE</b> <span style="float: right;"><b>"</b></span>									
Due to (or as a consequence of):									
d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
<b>- HYPERTENTION</b>									
<b>- CHRONIC OBSTRUCTIVE LUNG DISEASE</b>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  M.D.		29c. License number <b>D 23300</b>		29d. Date signed (Month, Day, Year) <b>JULY 11th 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SUDHIR D. PATEL 2600 Liberty Rd. BALTO MD. 21215</b>									
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22187

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL CARTER KLINE

2. Date of Death

JULY 12, 1999

3. Time of Death

7:22

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

291 16 1815

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

03 30 1922

9. Birthplace (State or Foreign Country)

Cleveland, OH

Usual Residence of Decedent

10a. State

Florida

10b. County

Manatee

10c. City, Town or Location

Bradenton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

227 Sherwood Drive

10f. Zip Code

34210

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Tire Company

17. Father's Name (First, Middle, Last)

Albert M. Kline

18. Mother's Name (First, Middle, Maiden Surname)

Pauline (Carter)

19a. Informant's Name/Relationship (Type, Print)

Mary Kline / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

227 Sherwood Drive, Bradenton, FL 34210

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Balto.-Washington

Date

7/14/99

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

▶ Mary K. Marshall

22. Name and Address of Facility

Sterling-Ashton-Schwab Funeral Home Inc.

736 Edmondson Ave., Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SUSPECTED VENTRICULAR FREE WALL RUPTURE

Due to (or as a consequence of):

MYOCARDIAL INFARCTION

2 DAYS

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ Timothy Low M.D.

29c. License number

D 24034

29d. Date signed (Month, Day, Year)

7/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMOTHY LOW, MD, 7601 OSLER DRIVE, TOWSON, M.D 21204

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

▶ [Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22188

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gwendolyn Kelley				2. Date of Death Month Day Year July 11, 1999		3. Time of Death 11 P.M.						
	4a. Facility Name (If not institution, give street and number) 71 Dundalk Avenue				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 216-03-3458		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 07/25/1910		9. Birthplace (State or Foreign Country) W. VA				
	Usual Residence of Decedent												
10a. State Md		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 71 Dundalk Avenue				10f. Zip Code 21222		10g. Citizen of What Country? USA							
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary			16b. Kind of Business/Industry Banking						
17. Father's Name (First, Middle, Last) Isaac M. Kelley					18. Mother's Name (First, Middle, Maiden Surname) Hilda Sullivan								
19a. Informant's Name/Relationship (Type, Print) Marlene Langdon/sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1329 Brook Road, Catonsville, Md 21228								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		Date 7/16		20c. Location - City or Town, State Baltimore, Md						
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring Road, Balto, Md 21222								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arrhythmia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death Immediate			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 					29c. License number 023365		29d. Date signed (Month, Day, Year) 7/13/99						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick W. White, 716 Maiden Lane #205, Balt., MD 21228													
31. Date filed (Month, Day, Year) JUL 14 1999			32. Registrar's Signature 										

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

Reg. No.

99 22189

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22190

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bertha A. Lutche</b>				2. Date of Death Month <b>July</b> Day <b>9</b> Year <b>1999</b>		3. Time of Death <b>7:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Rock Springs Village Nursing Home</b>				4b. City, Town, or Location of Death <b>Forest Hill</b>		4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>213-18-3687</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 30, 1911</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>711 High Plain Drive</b>		10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (14 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Martin Leyko</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha Kowalski</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Harriet M. Owens (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>711 High Plain Drive, Bel Air, MD. 21014</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crest Lawn Mem'l Gardens</b>		20c. Location - City or Town, State <b>Marriottsville, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Rd., Bel Air, MD 21014</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>END STAGE congestive Heart Failure</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospitel: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>027975</b>	
29d. Date signed (Month, Day, Year) <b>7/9/99</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL McNeen 615 Mac Phail Rd Bel Air Md 21014</b>		31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22191

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HERLEN LYNCH</b>				2. Date of Death Month Day Year <b>July 09, 1999</b>		3. Time of Death <b>23:26</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-26-5611</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10-5-1931</b>	9. Birthplace (State or Foreign Country) <b>Chester, MD.</b>
	Usual Residence of Decedent							
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3910 RIDGEWOOD AVE</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>ARMY</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>BLACK</b>		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>WATERMAN</b>		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <b>JAMES LYNCH SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GWENDOLYN COLEON</b>				
19a. Informant's Name/Relationship (Type, Print) <b>RUTH LYNCH</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3910 RIDGEWOOD AVE BALTO.MD 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CROWNSVILLE VETERANS</b>		Data <b>7-16-99</b>		20c. Location - City or Town, State <b>CROWNSVILLE, MD</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>HOWELL FUNERAL HOME 4600 LIBERTY HIGHTS AVE, BALTO.MD. 21207</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Intracranial Hemorrhage of Ventricle</b> Due to (or as a consequence of):  b. <b>Systemic Hypertension</b> Due to (or as a consequence of):  c. <b>COMPROMISED AIRWAYS</b> Due to (or as a consequence of):  d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  ONE AND A HALF HOURS								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>AS2402321-9443</b>		29d. Date signed (Month, Day, Year) <b>July 09, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Uguchi Erondu, MD PhD, Sinai Hospital, 2401 West Belvedere Avenue, Maryland 21215</b>								
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Herlen Lynch  
Baltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

89 22192

Physician  
/ Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

SYBIL

2. Date of Death

Month Day Year  
JULY 7 1999

3. Time of Death

1419

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

NA

5. Social Security Number

178-62-1777

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

28

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11-20-70

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

NY

10b. County

NA

10c. City, Town or Location

Painted Post

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

15 Dream North

10f. Zip Code

14870

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

18b. Kind of Business/Industry

Full-time

17. Father's Name (First, Middle, Last)

Frederick Felder

18. Mother's Name (First, Middle, Maiden Surname)

Gloria J. Clark

19a. Informant's Name/Relationship (Type, Print)

Samuel Lennon, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Dream North Painted Post, NY 14870

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Peace Cemetery 07-16-99 Philadelphia, PA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C. March FH 1101 E. North Avenue23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Right Ventricular Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

45 min.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Pulmonary Hypertension

Due to (or as a consequence of):

6 months

c. Lupus

Due to (or as a consequence of):

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Type, Print)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

PES-000

29d. Date signed (Month, Day, Year)

JULY 7 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SACAS WISSELL, MD 600 W. Wolfe St, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/ Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22193

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>FRANCES LLOYD</b>					2. Date of Death Month Day Year <b>JULY 10 1999</b>		3. Time of Death <b>2:10 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
<b>Funeral Director</b>	5. Social Security Number <b>218 92 2994</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>36</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 31, 1963</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>24 Cedar Hill Road</b>					10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>U.S.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Office Secretary</b>			16b. Kind of Business/Industry <b>ARA Mark Vending</b>		
17. Father's Name (First, Middle, Last) <b>Joseph B. Lloyd</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Dolores Conners</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Hammett / Sister</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11539 Palo Alto Road Lusby, Maryland 20657</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>7/13/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC CARCINOMA OF BREAST</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>									Approximate Interval Between Onset and Death <b>2 1/2 YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier <b>Rubina Ehtesham PGY III</b>		29c. License number <b>AS2441614-A2</b>		29d. Date signed (Month, Day, Year) <b>JULY 10, 1999.</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RUBINA EHTESHAM HARBOR HOSPITAL CENTER 3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND 21225</b>									
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMENDED ITEM #7 PER FH G773 7/14/99 AH

99 22194

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ROBERT (N.M.N.) MAYER</b>		2. Date of Death Month <b>July</b> Day <b>12</b> Year <b>1999</b> 9 AM		3. Time of Death <b>9 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>ROSEWOOD CENTER</b>		4b. City, Town, or Location of Death <b>QUINCY MILLS</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>215-09-3234</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> 55 Yrs.	
8. Data of Birth (Month, Day, Year) <b>May 20, 1944</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent					
10a. State <b>MD.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Kingsville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>911 Louis Lane</b>		10f. Zip Code <b>21087</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>		16b. Kind of Business/Industry <b>N/A</b>	
17. Father's Name (First, Middle, Last) <b>Xavier A. Mayer</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Englehardt</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Albert W. Mayer (Brother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>911 Louis Lane, Kingsville, MD. 21087</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bohemian National Cem.</b>		20c. Location - City or Town, State <b>7/15/99 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Robert J. Sodachy</b>		22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CHRONIC ACTIVE HEPATITIS</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Down's Syndrome</b>					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>E.P. Williamson M.D.</b>		29c. License number <b>D11171</b>		29d. Date signed (Month, Day, Year) <b>July 12, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>E.P. WILLIAMSON 405 FREDERICK ROAD CATONSVILLE</b>					
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22195

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA Marie Miller

2. Date of Death

Month Day Year  
July 10 99

3. Time of Death

1535

4a. Facility Name (If not institution, give street and number)

311 W. Riverview Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216 20 1676

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 14, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

311 W. Riverview Road

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

August Holthaus

18. Mother's Name (First, Middle, Maiden Surname)

Anna Marie

19a. Informant's Name/Relationship (Type, Print)

Cindy Niemiera / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3500 Horton Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holy Cross Cemetery

Date

7/14/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jerome Zramkowski

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Hypovolemia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

UNK.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Vaginal Hemorrhage  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

William P. Jones, MD Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

7/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 1695 America 21030

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

Anna B. Spahr

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

James M. Smith

James M. Smith

James M. Smith



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22196

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MARGARET ROSEMARY NEFF

2. Date of Death

Month Day Year  
JULY 12 1999

3. Time of Death

10:26 AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216 18 4381

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 27, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3808 - 5th Street

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

St. Rose of Lima Ch.  
Catholic Church

17. Father's Name (First, Middle, Last)

Alfred Neff

18. Mother's Name (First, Middle, Maiden Surname)

Clara Fiori

19a. Informant's Name/Relationship (Type, Print)

Robert D. Neff / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25980 Shults Road Henderson, Maryland 21640

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holy Cross Cemetery

Date

7/16/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

2 hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

6 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

RESIDENT PHYSICIAN

29c. License number

P13140

29d. Date signed (Month, Day, Year)

JULY 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMEER BADE MD, 3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND 21225

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22197

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Patricia Oswinkle</b>				2. Date of Death Month Day Year <b>JULY 10, 1999</b>		3. Time of Death <b>5:37 P.M.</b>		
	4a. Facility Name (If not Institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>				4b. City, Town, or Location of Death <b>ESSEX</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>212-06-5480</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>30</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 9, 1969</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>2234 Firethorn Road</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>		16b. Kind of Business/Industry <b>Retail Food</b>			
17. Father's Name (First, Middle, Last) <b>William Kelley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Hauf</b>					
19a. Informant's Name/Relationship (Type, Print) (husband) <b>Mr. William C. Oswinkle</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2234 Firethorn Road, Baltimore, MD 21220</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem'l Gardens</b>		Date <b>7/16/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Seizure Disorder complicated by drowning</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>7-10-99</b>		28b. Time of Injury <b>16 39 M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Drowned in bath tub</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Residence</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2234 Firethorn Rd</b>							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 11, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R. Fowler</b>		31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature 					
State Registrar									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22198

ITEMS: #18 PER F.H. G773 7-14-99 WR.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN WILLIAM OPPIDO

2. Date of Death

Month Day Year  
July 12, 1999

3. Time of Death

11:20 a.m.

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

051-01-9401

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 15, 1905

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10706 Westcastle Place

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Executive

16b. Kind of Business/Industry

Automotive Industry

17. Father's Name (First, Middle, Last)

ROCCO

OPPIDO

18. Mother's Name (First, Middle, Maiden Surname)

TERESA LAGRUA

DeGUIDA

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elsie Rose Oppido Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10706 Westcastle Place Cockeysville, Maryland 21030

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greenmount Crematory

Date

7/14/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert M. Kratz

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.  
6500 York Rd. Baltimore, Md. 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. PANCREATIC CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

HOSPICE

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier.

Dr. Tariq Mahmood

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

T. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22199

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

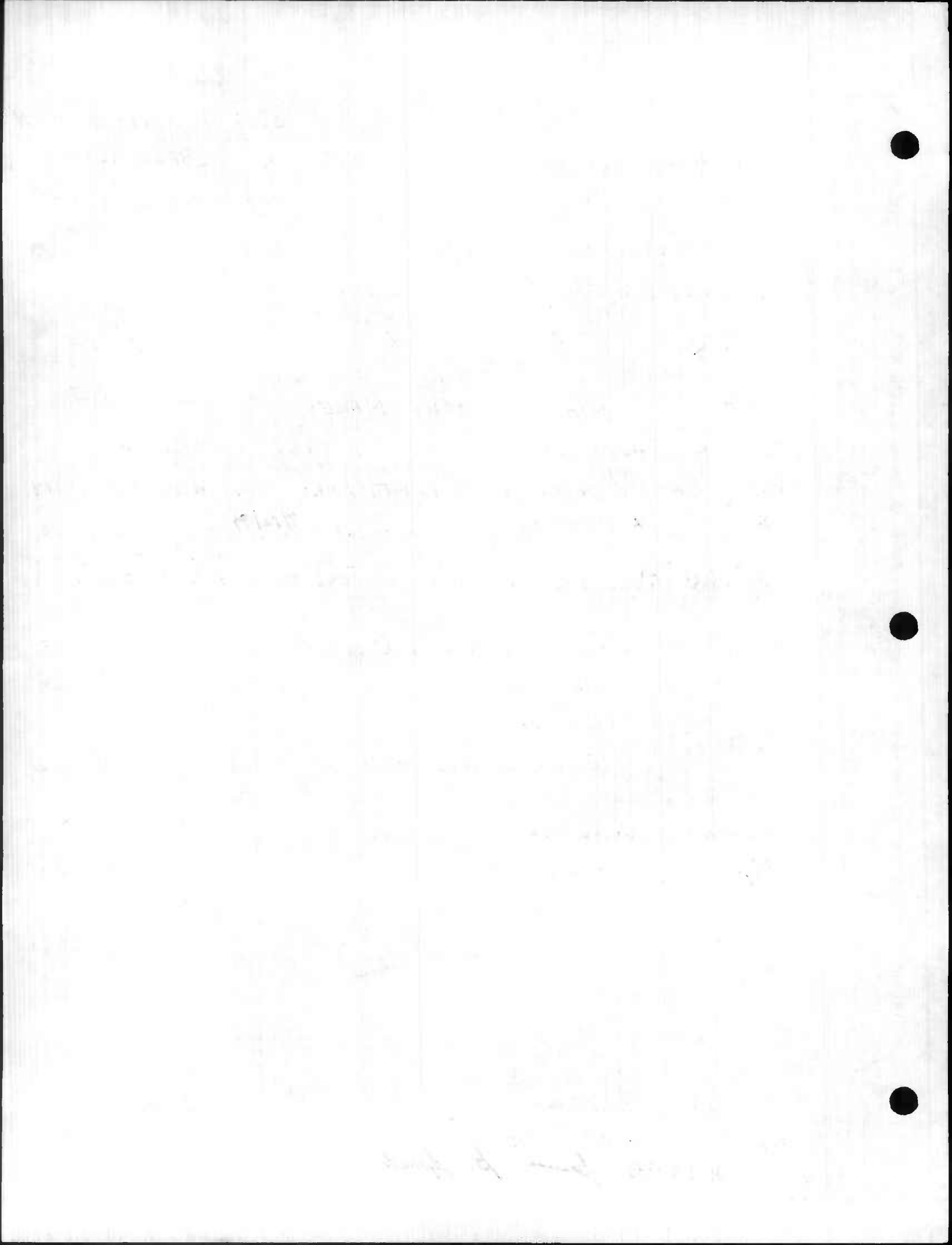
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>VIOLA MAE OXLEY</b>						2. Date of Death Month Day Year <b>JULY 11 1999</b>		3. Time of Death <b>8:45PM</b>	
4a. Facility Name (If not institution, give street and number) <b>HERITAGE CENTER</b>				4b. City, Town, or Location of Death <b>DUNDALK</b>		4c. County of Death <b>BALTIMORE</b>			
5. Social Security Number <b>235-52-8718</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year <b>MAY 20, 1913</b>		9. Birthplace (State or Foreign Country) <b>WEST VA</b>	
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>BALTO. CO.</b>		10c. City, Town or Location <b>N/A</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>20 PLATT LANE</b>				10f. Zip Code <b>21219</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOME MAKER</b>			16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>BUREN THOMPSON</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>LOUISE UNKNOWN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>PATTY CROY / DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20 PLATT LANE BALTIMORE MD 21219</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ROSE LAWN MEMORIAL GARDENS</b>			20c. Location - City or Town, State <b>PRINCETON W. VA</b>		Date <b>7/12/99</b>	
21. Signature of Funeral Service Licensee <b>[Signature]</b>					22. Name and Address of Facility <b>ALTENBURG FUNERAL HOME, P.A. 6009 HARFORD RD BALTO. MD 21214</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  b. <b>ANAEMIA</b> Due to (or as a consequence of):  c. <b>THROMBOCYTOPENIA</b> Due to (or as a consequence of):  d. <b>ESSENTIAL HYPERTENSION</b>								Approximate Interval Between Onset and Death  <b>1 YEAR</b> <b>8 YEARS</b> <b>5 YEARS</b> <b>10 YEARS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>ALZHEIMER'S DEMENTIA</b> <b>MYELODYSPLASTIC SYNDROME</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D14160</b>		29d. Date signed (Month, Day, Year) <b>07-12-1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HARJIT SINGH MD. 5410 RITCHIE HWY BALTIMORE, MD 21225</b>									
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>				32. Registrar's Signature <b>[Signature]</b>					

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22200

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Phillips

2. Date of Death

Month Day Year  
July 10, 1999

3. Time of Death

10:44am

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-44-9196

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 1, 1944

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

3048 Abell Avenue

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Real Estate

16b. Kind of Business/Industry

Broker

17. Father's Name (First, Middle, Last)

Richard O. Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Ryder

19a. Informant's Name/Relationship (Type, Print) (Wife)

Mary Carol Phillips

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3048 Abell Avenue Balto, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Balto-Wash Crematory 7/12

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc  
3631 Falls Rd Balto, MD 2121123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Myocardial Infarction  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D0038026

29d. Date signed (Month, Day, Year)

7/12/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mark King Union Memorial Hospital

201 East University  
Pkwy Balto, Mo.

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

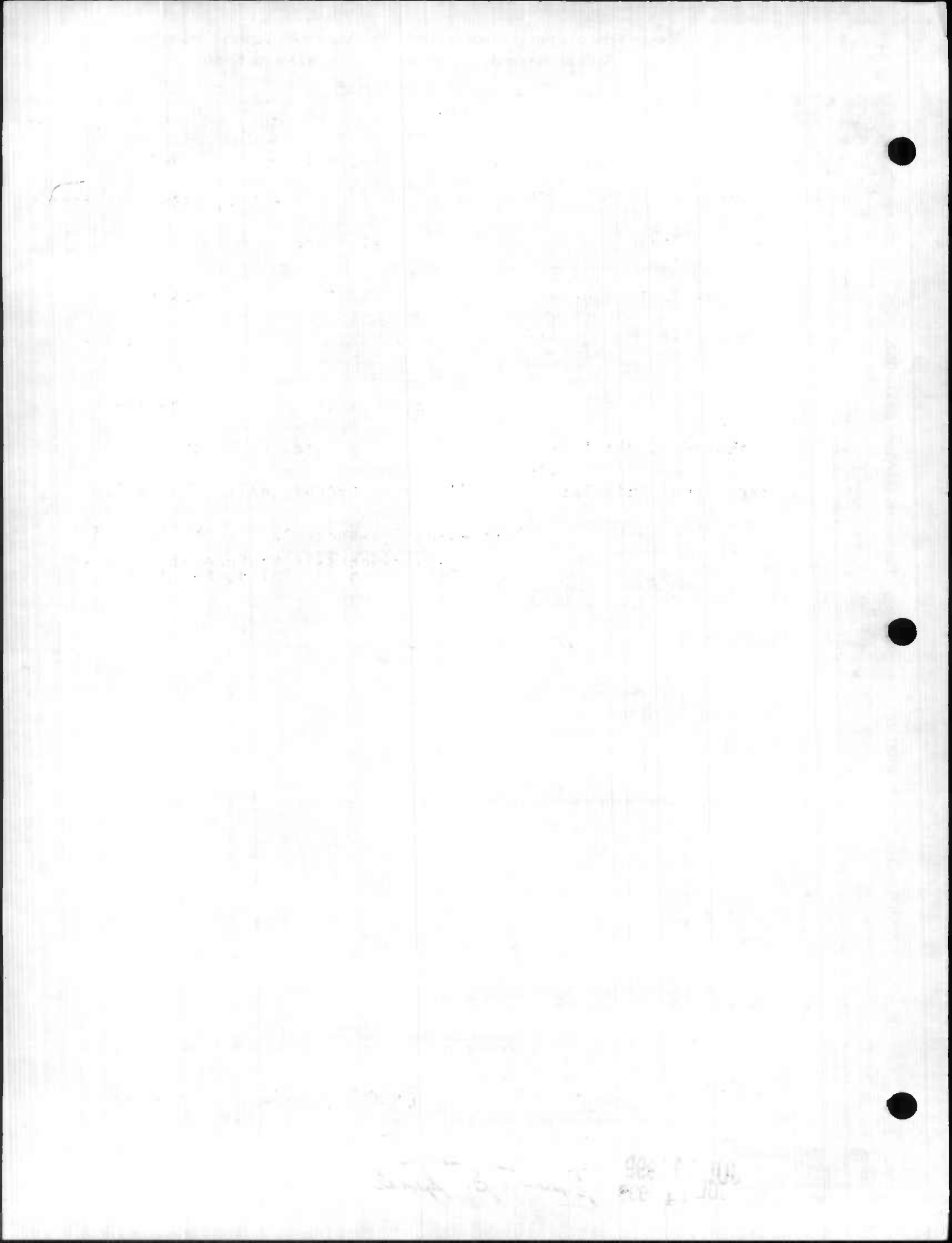
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

MD CASE

27410



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22201

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Lillie Josephine Pritchard

2. Date of Death

Month Day Year  
July 12 1999

3. Time of Death

2:58pm

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-28-6882

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 25, 1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11 Oakmere Road

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Filbert Sias

18. Mother's Name (First, Middle, Maiden Surname)

Norma L. Chevron

19a. Informant's Name/Relationship (Type, Print)

Patricia Champagne Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Oakmere Road, Owings Mills, Maryland 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sias Cemetery

Date

7/17/99

20c. Location - City or Town, State

West Hamlin, W. Virginia

21. Signature of Funeral Service Licensee

*Laurel H. Carpenter*

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc. 21211  
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. massive @ ischemic CVA

Due to (or as a consequence of):

c. vascular disease

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

massive @ ischemic CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Scott Reeder MD PhD*

29c. License number

P13217

29d. Date signed (Month, Day, Year)

July 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Reeder-Sinai Hospital Baltimore, M.D. 21215

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

*B. Sparks*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



99-3875-510

BRIAN PAYLOR

ASP Amended Item#20b,20c perFH G773.7/16/99 EW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22202

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Brian R. Paylor</b>				2. Date of Death Month Day Year <b>JULY 06 1999</b>		3. Time of Death <b>1:09 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>MARYLAND SHOCK TRAUMA</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-96-5276</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>18</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 27, 1980</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1658 N. Warwick Ave.</b>			10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Afro-American</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (14 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unemployed</b>			16b. Kind of Business/Industry <b>N/A</b>		
	17. Father's Name (First, Middle, Last) <b>Leroy Paylor</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Robin Gault</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Leroy Paylor (Father)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1019 Appleton St. Balto. Md. 21217</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT ZION</b>		20c. Location - City or Town, State <b>Lanstowne MD</b>		20d. Date <b>7/19/99</b>	
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple gunshot wounds</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>7-5-99</b>		28b. Time of Injury <b>2357P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SHOOTING WOUNDS</b>
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Wayne D. Sparks</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JULY 06, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>USAGP and D. KOSOW PER. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <b>Wayne D. Sparks</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22203

AMEND ITEM: #8 PER F.H. G773 7-17-99 WR.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ilene Patterson</b>				2. Date of Death Month Day Year <b>July 9<sup>th</sup> 1999</b>		3. Time of Death <b>7:45pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Elder Care Caton Manor</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>241-28-5094</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>04-13-99</b>	9. Birthplace (State or Foreign Country) <b>SC</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3330 W. Wilkens Avenue</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>			16b. Kind of Business/Industry <b>Housewife</b>	
17. Father's Name (First, Middle, Last) <b>Leroy Saddler</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Robinson</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Williams</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21216 2952 Clifton Avenue Baltimore, Maryland</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Kings Mem. Pk. Cem.</b>		Date <b>07-15-99</b>		20c. Location - City or Town, State <b>Randallstown, MD</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Bilateral Pneumonia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>hours</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Rheumatoid arthritis</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>[Signature]</i>						
29c. License number <b>D-40521</b>		29d. Date signed (Month, Day, Year) <b>July 9, 1999</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. OCHANE</b>		<b>3330 Wilkens Avenue Suite 302 Baltimore, MD 21229</b>						
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22204

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Betty Party</u>				2. Date of Death Month <u>July</u> Day <u>11</u> Year <u>1999</u>				3. Time of Death <u>15:45</u>			
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore, MD</u>				4c. County of Death <u>Baltimore</u>			
Funeral Director	5. Social Security Number <u>228-38-4817</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>64</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Dec. 25, 1934</u>		9. Birthplace (State or Foreign Country) <u>South Carolina</u>			
	Usual Residence of Decedent				10a. State <u>Maryland</u>				10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Edgemere</u>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <u>46 Shore Road</u>				10f. Zip Code <u>21219</u>		10g. Citizen of What Country? <u>United States</u>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11 Years</u> College (1-4 or 5+) <u></u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>				16b. Kind of Business/Industry <u>Own Home</u>			
	17. Father's Name (First, Middle, Last) <u>Hansel E. Carter</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Lorene House</u>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Vicky L. Party/Daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>46 Shore Road Edgemere, Maryland 21219</u>							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Holly Hill Mem. Gdns.</u>		20c. Location - City or Town, State <u>Middle River, MD</u>		20d. Date <u>7/15/1999</u>					
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <u>D. E. Ruck</u>				22. Name and Address of Facility <u>Duda-Ruck Funeral Home of Dundalk, Inc.</u> <u>7922 Wise Ave. Dundalk, Maryland 21222</u>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>Hypokalemia</u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>End-stage renal failure</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				Approximate Interval Between Onset and Death <u>48 hours</u>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>98026</u>			
	29d. Date signed (Month, Day, Year) <u>July 11, 1999</u>											
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Sanjay Garuda 4940 Eastern Avenue Baltimore, Maryland 21236</u>											
	31. Date filed (Month, Day, Year) <u>JUL 14 1999</u>				32. Registrar's Signature <u>[Signature]</u>							

ORIGINAL



99 22205

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) JIM ROBINSON, III

2. Date of Death Month Day Year July 7, 1999

3. Time of Death 6:44am

4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death GLEN BURNIE

4c. County of Death AA COUNTY

5. Social Security Number 417-54-7528

6. Sex XX M 20 F

7. Age (In yrs. last birthday) 52 Yrs.

8. Date of Birth (Month, Day, Year) 11-19-1946

9. Birthplace (State or Foreign Country) ALABAMA

10a. State MARYLAND

10b. County ANNE ARUNDEL

10c. City, Town or Location SEVERN

10d. Inside City Limits 10 Yes 20 No

10e. Street and Number 1813 RICHFIELD DRIVE, P.O. BOX 44

10f. Zip Code 21144

10g. Citizen of What Country? U.S.A.

11. Marital Status 10 Never Married 20 Married 30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No 1974-1976

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No Specify: BLACK

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) 9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRIVER

16b. Kind of Business/Industry U.S. GOVERNMENT

17. Father's Name (First, Middle, Last) JIM ROBINSON, JR.

18. Mother's Name (First, Middle, Maiden Surname) LILLIE BELL

19a. Informant's Name/Relationship (Type, Print) MARY THURSTON (COMPANION)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 RICHFIELD DRIVE, P.O. BOX 44, SEVERN, MD. 21144

20a. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) OAKWOOD CEMETERY

20c. Location - City or Town, State MOBILE, ALABAMA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed? 10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No

25. Was case referred to medical examiner? 10 Yes 20 No

26. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending Investigation 60 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number D43977

29d. Date signed (Month, Day, Year) July 7 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JUL 14 1999





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22206

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM HAYNIE RICE</b>						2. Date of Death Month Day Year <b>JULY 08 1999</b>		3. Time of Death <b>04:40PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>						4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>250-26-0330</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 1, 1924</b>		9. Birthplace (State or Foreign Country) <b>South Carolina</b>	
	Usual Residence of Decedent									
10a. State <b>South Carolina</b>		10b. County <b>Charleston</b>		10c. City, Town or Location <b>Isle of Palms</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>7 55th. Avenue</b>		10f. Zip Code <b>29541</b>		10g. Citizen of What Country? <b>U.S.A.</b>						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 years</b> College (1-4 or 5+) <b>4 years</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>President/Owner</b>				16b. Kind of Business/Industry <b>Rice Mills</b>		
17. Father's Name (First, Middle, Last) <b>Max Rice</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Janie Haynie</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Pauline Thomson Rice</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7 55th. Ave. Isle of Palms, South Carolina 29541</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Belton Cemetery</b>		20c. Location - City or Town, State <b>7-11-99 Belton, South Carolina</b>				
21. Signature of Funeral Service Licensee <b>George J. Fenamore</b>						22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>pulmonary embolus</b> Due to (or as a consequence of): b. <b>coagulopathy</b> Due to (or as a consequence of): c. <b>esophageal squamous cell cancer</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>1 hour</b> <b>1-2 years</b> <b>1-2 years</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>history of stroke requiring anticoagulation</b>										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Charles C. Delta Santana MD PhD</b>						29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>7/8/1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles C. Delta Santana MD PhD Department of Otolaryngology Johns Hopkins Hospital</b>										
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <b>Johns Hopkins Hospital</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22207

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM STANLEY SHUSTA, SR.</b>				2. Date of Death Month Day Year <b>July 13, 1999</b>				3. Time of Death <b>1:30 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>602 Churchill Road, Apt. L</b>				4b. City, Town, or Location of Death <b>Bel Air</b>				4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>149-05-2918</b>		6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Oct. 2, 1914</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>	
Usual Residence of Decedent		10d. Inside City Limits <b>1</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>602 Churchill Road, Apt. L</b>		10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b> College (1-4 or 5+) <b>College</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self Employed</b>		16b. Kind of Business/Industry <b>Service Station</b>		17. Father's Name (First, Middle, Last) <b>Dominic Shusta</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Novak</b>		19a. Informant's Name/Relationship (Type, Print) <b>Shirley R. Shusta (Wife)</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>602 Churchill Rd., Apt. L, Bel Air, MD. 21014</b>		20a. Method of Disposition <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee <b>Robert J. Zdobych</b>		
22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014</b>		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Adenocarcinoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>two months</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)		27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> M <b>28c. Injury at Work?</b> <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No				
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Mark Wild M.D.</b>		29c. License number <b>435522</b>		29d. Date signed (Month, Day, Year) <b>July 14, 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mark Wild M.D., 2-North Avenue, Suite 101, Bel Air, MD. 21014</b>		31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <b>B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22208

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carroll Tully Scott

2. Date of Death

Month Day Year  
July 9, 1999

3. Time of Death

8:58 AM

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

217-09-2968

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 1, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9903 Fox Hill Road

10f. Zip Code

21128

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Project Manager

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Spencer Scott

18. Mother's Name (First, Middle, Maiden Surname)

Marie Zeller

19a. Informant's Name/Relationship (Type, Print)

Mrs. Virginia Scott (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9903 Fox Hill Road, Perry Hall, MD 21128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

Date

7/13/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert J. Rodars

22. Name and Address of Facility

Schimunek Funeral Home, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Cardiopulmonary Arrest  
Due to (or as a consequence of):

b.

MI, arrhythmia  
Due to (or as a consequence of):

c.

ASHO, CAD, Mitral Stenosis  
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD  
CUA, Dementia  
HTN

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical Certification: To Be Completed by Physician/Medical Examiner

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen J. Elbert MD

29c. License number

D0053622

29d. Date signed (Month, Day, Year)

7/9/99

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

STEPHEN ELBERT MD 317 J. Union Ave H&amp;G Md.

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

7/9/99 08:58 AM

Scott, Carroll Tully

AH 741

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1892

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1892

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1892

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1892

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State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #23a part II&amp; II PER MD G773 7/14/99 AH

## Certificate of Death

Reg. No.

99 22209

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

TILLIE

SILVERSTEIN

2. Date of Death

Month Day Year  
JULY 1, 1999

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

MANOR CARE NURSING HOME

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

212-05-9562

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APR. 15, 1913

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1401 BLAIR MILL ROAD #402

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

MORRIS

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE

RUSHNEZSKY

19a. Informant's Name/Relationship (Type, Print)

ABE SILVERSTEIN / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15682 JEANETTE - SOUTHFIELD, MICHIGAN 48075

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MOGAN ABRAHAM CEMETERY

Date

7/1/99

20c. Location - City or Town, State

ROSEDALE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. pneumonia BRONCO PNEUMONIA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. aspiration  
Due to (or as a consequence of):

2 days

c. cerebrovascular accident  
Due to (or as a consequence of):

6 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation CEREBROVASCULAR ACCIDENT

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 51015

29d. Date signed (Month, Day, Year)

July 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ellen Pinholt MD 5530 Wisconsin Ave #1045 Chevy Chase, MD

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

State  
Registrar

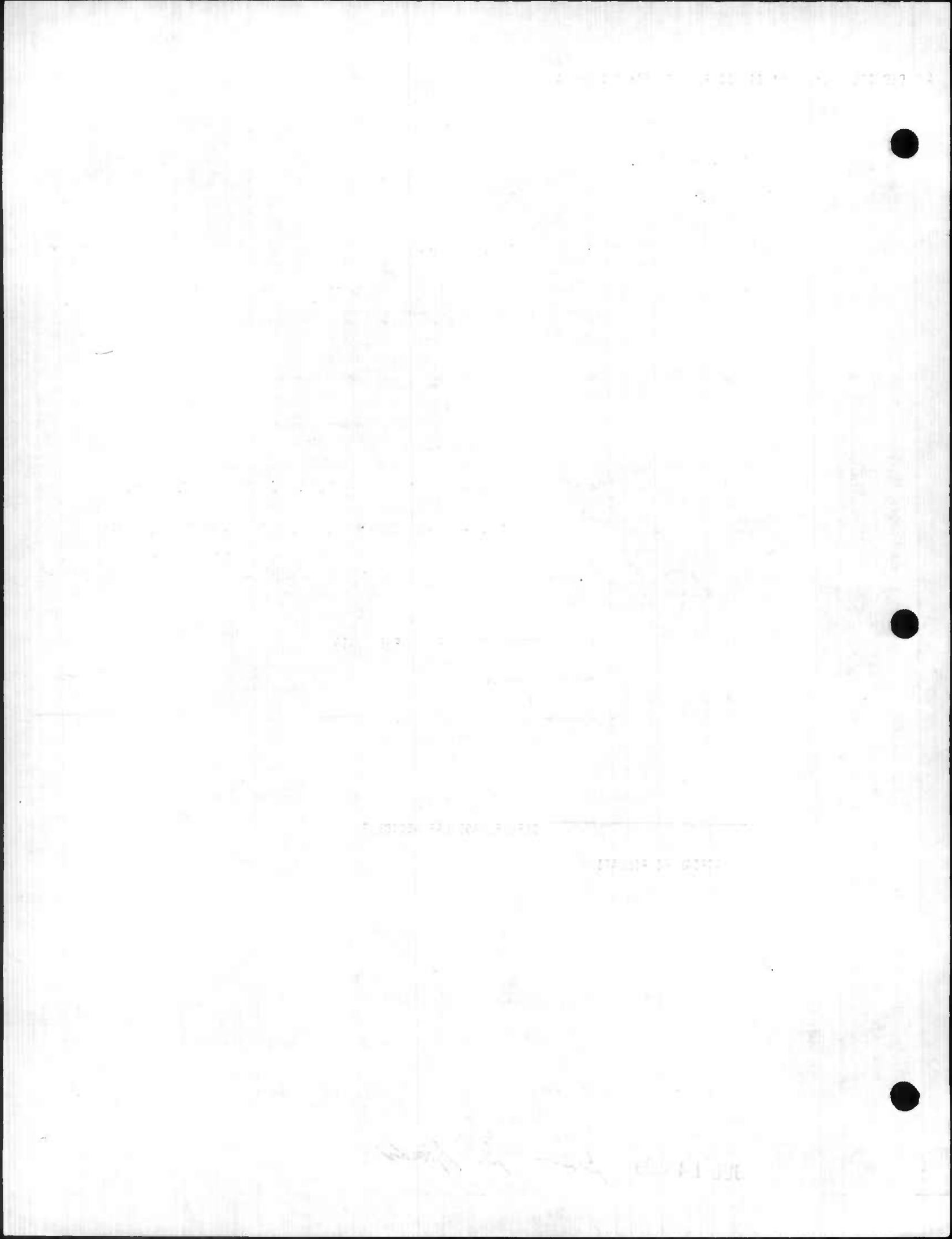
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22210

AMENDED ITEM #23a PART I &amp; II PER FH G773 7/14/99 AH

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Salisbury

2. Date of Death  
Month Day Year

June 9 1999

3. Time of Death

7:15 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Manor Care Chevy Chase

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

579-22-8457

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Nov. 17, 1900

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8700 Jones Mill Road

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☐ No Specify:

unknown

14. Race - American Indian,  
Black, White, etc.

Specify: black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. pneumonia BRONCO PNEUMONIA

Due to (or as a consequence of):

2 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. aspiration

Due to (or as a consequence of):

2 days

c. cerebrovascular accident

Due to (or as a consequence of):

3 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus CEREBROVASCULAR ACCIDENT

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ellen M Pinhoir MD

29c. License number

D51015

29d. Date signed (Month, Day, Year)

June 10, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ellen Pinhoir MD 5530 Wisconsin Ave Suite #1045 Chevy Chase MD

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or item 23a or 23e show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

39 22211

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JOHN O. SMIT SR.

2. Date of Death

JULY 8 1999

3. Time of Death

5:00 PM

4a. Facility Name (If not institution, give street and number)

3415 O'DONNELL ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-05-5799

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 3, 1915

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3415 O'DONNELL ST.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BREWER

16b. Kind of Business/Industry

BREWER

17. Father's Name (First, Middle, Last)

JOHN O. SMIT

18. Mother's Name (First, Middle, Maiden Surname)

MARIE STROBEL

19a. Informant's Name/Relationship (Type, Print)

JOHN O. SMIT JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7506 RIDDLE AVE. BALTIMORE, MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAKLAWN CEM.

Date

JULY 10 1999

20c. Location - City or Town, State

BALTO. CO. MD.

21. Signature of Funeral Service Licensee

Thomas J. Skarda Jr.

22. Name and Address of Facility

HOFFMAN-SKARDA 3218 HUDSON ST BALTO., MD. 21224

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease 40yr.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Venous Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Robert Vissing

29c. License number

D33897

29d. Date signed (Month, Day, Year)

7/9/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert Vissing, MD 3400 E Bank St Baltimore, MD 21224

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

7-13-99 J.A. State of Maryland / Department of Health and Mental Hygiene  
AMEND ITEM#10a-19b PER K.B. G773 Certificate of Death

Reg. No. 99 22212

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BB Stancil</b>				2. Date of Death Month Day Year <b>April 12 99</b>		3. Time of Death <b>0145Am</b>		
	4a. Facility Name (If not institution, give street and number) <b>SINAI Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>City</b>		
Funeral Director	5. Social Security Number <b>N/A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days		8. Date of Birth (Month, Day, Year) <b>4/11/99</b>		
	10a. State <b>MD.</b>		10b. County <b>BALTO.</b>		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>8204 SCOTTS LEVEL ROAD</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) <b>0 0</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INFANT</b>			16b. Kind of Business/Industry <b>INFANT</b>			
17. Father's Name (First, Middle, Last) <b>FRANK V. STANCIL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANGELICA WASHINGTON</b>					
19a. Informant's Name/Relationship (Type, Print) <b>SINAI HOSP.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2401 BELVEDERE AVE. 21215</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SINAI HOSP</b>		Data <b>4-14-99</b>		20c. Location - City or Town, State <b>Baltimore MD</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>SINAI HOSP 2401 W. BELVEDERE AVE 21215</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Congenital pneumonia</b> Due to (or as a consequence of):  b. <b>Sepsis</b> Due to (or as a consequence of):  c. <b>extreme prematurity</b> Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death  <b>14 hrs</b> <b>14 hrs</b> <b>14 hrs</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>[Signature]</i>			29c. License number <b>DY0362</b>		29d. Date signed (Month, Day, Year) <b>4/12/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas P. O'Brien M.D. Sinai Hosp. of Baltimore</b>									
31. Date filed (Month, Day, Year) <b>JUN 23 1999</b>			32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22213

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cathlene Sutton

2. Date of Death

Month  
JulyDay  
8Year  
99

3. Time of Death

12:10p

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Geriatric Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

238-36-5210

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 13, 1923

9. Birthplace (State or Foreign Country)

Mt. Olive, N.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

1401 North Lakewood Ave/BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1401 North Lakewood Ave Apt. 401

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

J.P. Taylor  
Factories

17. Father's Name (First, Middle, Last)

Alonzo Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Tart

19a. Informant's Name/Relationship (Type, Print)

Bertha Bluford / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1401 N. Lakewood Ave Apt. 401 Balto. Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. OLIVE MEM. PARK

Date

7-9-99

20c. Location - City or Town, State

MT. OLIVE, NC

21. Signature of Funeral Service Licensee

Willa

22. Name and Address of Facility

HOWELL FUNERAL HOME

4600 LIBERTY HGHTS AVE, BALTO. MD 21207

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CVA

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5d

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Suzanne M. Funder

29c. License number

D38679

29d. Date signed (Month, Day, Year)

7/9/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

5505 Hopkins Bayview Circle Baltimore MD 21224

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22214

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sandra Kay Seibert				2. Date of Death Month Day Year July 11, 1999		3. Time of Death 5:15 PM	
	4a. Facility Name (If not institution, give street and number) 8111 Raymond Avenue				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-40-1890		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) May 14, 1943	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 8111 Raymond Avenue		10f. Zip Code 21222	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bindery Worker				16b. Kind of Business/Industry Bindery		17. Father's Name (First, Middle, Last) William Henry Wills	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Sarah Jane Rugemer				19a. Informant's Name/Relationship (Type, Print) Husband Mr. Bernard W. Seibert		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8111 Raymond Avenue Dundalk, Maryland 21222	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery 7/15/1999		20c. Location - City or Town, State Baltimore, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee L. E. Reed				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. METASTATIC COLON CANCER Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Michael Querbach MD		29c. License number D33551	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) July 12, 1999				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ALLERBACH, 9000 FRANKLIN SQ. DR. Baltimore 21237		31. Date filed (Month, Day, Year) JUL 14 1999	
	32. Registrar's Signature B. Spinks				33. Date of Death July 11, 1999		34. Time of Death 5:15 PM	



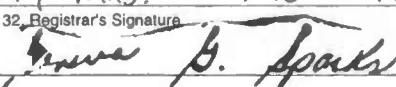
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22215

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Katherine Taylor</b>				2. Date of Death Month <b>July</b> Day <b>11</b> , Year <b>1999</b>		3. Time of Death <b>7:04 AM.</b>	
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>226-24-1068</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 31, 1924</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>14 Douglas Road</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Burl Shortt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Leola Prater</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Leon Taylor (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1904 Treeline Drive, Forest Hill, MD 21050</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem'l Gardens</b>		Data <b>7/14/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schmunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Bacterial Sepsis</b> Due to (or as a consequence of):  b. <b>Acute Renal Failure</b> Due to (or as a consequence of): <b>Ischemia</b>  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death  <b>7 days</b>  <b>14 days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Large Sacral Decubitus Ulcer,</b> <b>Diabetes Mellitus, Coronary Artery Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Cynthia Brown, MD</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>7-11-99</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Cynthia Brown, M.D. The Johns Hopkins Hospital Baltimore, MD.</b>								
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



99-4045-510

RAYMOND

UEBEL

AMEND#19a PER F.H. G774 8-11-99 J.A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22216

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Raymond F. Uebel</b>						2. Date of Death Month Day Year <b>JULY 11, 1999</b>		3. Time of Death <b>6:57P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>417 W. 24th STREET</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-09-8891</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 17, 1910</b>		9. Birthplace (State or Foreign Country) <b>Baltimore, MD</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>417 W. 24th Street</b>				10f. Zip Code <b>21211</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>				16b. Kind of Business/Industry <b>Mass Transit Authority</b>		
17. Father's Name (First, Middle, Last) <b>William Uebel</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Anna</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Karner</b> <b>INFORMANT</b> <b>Sister</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7953 Pipers Path Glen Burnie, Maryland 21061</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		Date <b>7/14/99</b>		20c. Location - City or Town, State <b>Freeland, Maryland</b>		
21. Signature of Funeral Service licensee 				22. Name and Address of Facility <b>Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>JULY 12, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. J. A. SPARKS 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date titled (Month, Day, Year) <b>JUL 14 1999</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22217

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Christine</b>		2. Date of Death Month Day Year <b>July 11, 1999</b>		3. Time of Death <b>17:15</b>
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>216-42-2626</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>53</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JULY 27, 1945</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3320 PRESSTMAN STREET</b>		
	10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH GRADE</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FACTORY WORKER</b>	
16b. Kind of Business/Industry <b>KAZABURG</b>		17. Father's Name (First, Middle, Last) <b>JACK</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>DELPHINE McFADDEN</b>	
19a. Informant's Name/Relationship (Type, Print) <b>ALENE TALLEY (SISTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1212 LAFAYETTE AVE. BALTO. MD. 21217</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		20c. Location - City or Town, State <b>LANSDOWNE, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Acidosis</b> Due to (or as a consequence of): b. <b>Sepsis</b> Due to (or as a consequence of): c. <b>Acute myocardial infarction</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>2 days</b> <b>2 days</b> <b>2 days</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus.</b> <b>Renal disease</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>July 11, 1999</b>	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Justina Wu Resident</b>		29c. License number <b>RES-000</b>	
29d. Date signed (Month, Day, Year) <b>July 11, 1999</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Justina Wu, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287</b>			
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature 			

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22218

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IRMA VENNEY				2. Date of Death Month Day Year 07- 10- 99				3. Time of Death 9:15pm	
	4a. Facility Name (If not institution, give street and number) IRVINGTON KNOLL CARE CENTER				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-28-7701		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 06-10-11		9. Birthplace (State or Foreign Country) NC	
	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 22 SOUTH ATHOL AVENUE				10f. Zip Code 21229		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify:			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 TH GRADE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE		16b. Kind of Business/Industry HEALTH CARE			
	17. Father's Name (First, Middle, Last) CLINTON MCIVER				18. Mother's Name (First, Middle, Maiden Surname) NAOMI					
	19a. Informant's Name/Relationship (Type, Print) SHIRLEY SCOTT FRIEND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 341 BEAUMONT AVE., BALTO. MD. 21228					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		20c. Location - City or Town, State BALTO. MD		20d. Date 7-15-99			
	21. Signature of Funeral Service Licensee Vaughn C. Greene				22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATL PIKE, BALTO. MD. 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Endstage Renal disease on Hemodialysis. Due to (or as a consequence of): b. Metabolic Encephalopathy Due to (or as a consequence of): c. Aspiration Pneumonia. Due to (or as a consequence of): d. Peripheral Vascular disease.									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anaemia.									
	Physician /Medical Examiner	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Dr. Al-Hamed, MD				29c. License number D52842		29d. Date signed (Month, Day, Year) 7/14/99.			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 Dolphin Street, Baltimore MD 21217.									
	31. Date filed (Month, Day, Year) JUL 14 1999									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22219

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Christopher D. Warfield</b>				2. Date of Death Month <b>July</b> Day <b>8</b> Year <b>1999</b>				3. Time of Death <b>14:48</b>		
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>214-38-8430</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 14, 1942</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
	Usual Residence of Decedent										
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>2516 W. FAYETTE STREET</b>				10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH GRADE</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TRUCK DRIVER</b>				16b. Kind of Business/Industry <b>COCA COLA BOTTLING CO.</b>			
17. Father's Name (First, Middle, Last) <b>EUGENE TURNER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BERNADINE WARFIELD</b>							
19a. Informant's Name/Relationship (Type, Print) <b>GERALDINE WARFIELD (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2516 W. FAYETTE STREET, BALTIMORE, MD. 21223</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESTERN STAR CEMETERY</b>		20c. Location - City or Town, State <b>MD. 21223 CATONSVILLE, MARYLAND</b>		20d. Date <b>07-13-99</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Stroke</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>P11515</b>			
				29d. Date signed (Month, Day, Year) <b>July 8 1999</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Benjamin H. Lowentritt, M.D. 22 S. Greene St. Baltimore, MD 21201</b>											
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

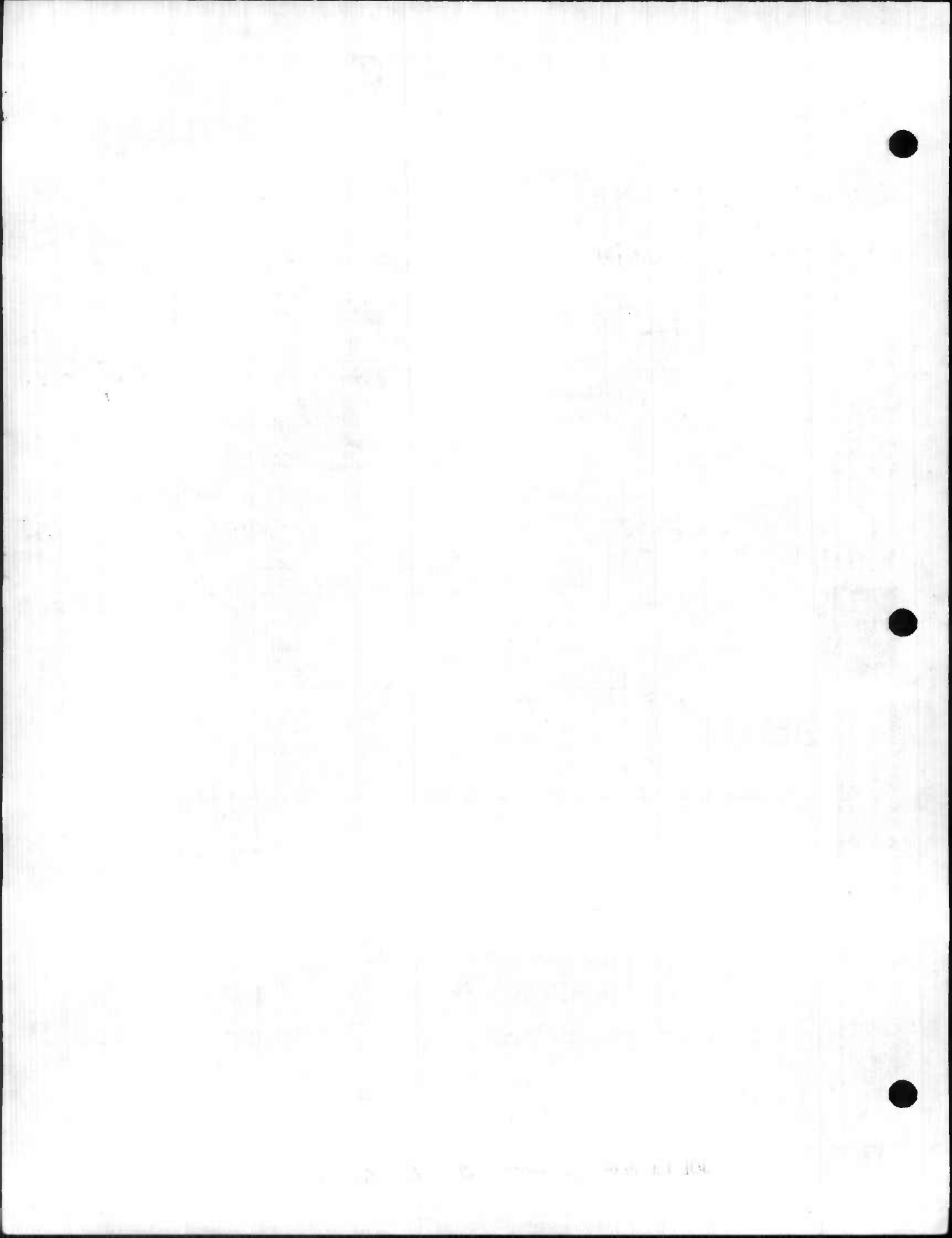
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #20B PER F.H. G773 7-14-99 WR.

## Certificate of Death

Reg. No.

99 22220

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Valerie G. White

2. Date of Death

Month Day Year  
July 13 1999

3. Time of Death

4:25 AM

4a. Facility Name (If not institution, give street and number)

Long Green Center - Gensis Eldercare

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-10-1717

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 29, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes, 2 ☒ No  
XXX

10e. Street and Number

7607 Knollwood Road

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Henry Goldsmith

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Kemp

19a. Informant's Name/Relationship (Type, Print)

Valerie White McCain

DTR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7607 Knollwood Road Towson, Maryland 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Greenmount Cemetery

Date

7-15-99

7/14/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Dennis Stephen Kenackis

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.  
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Failure to Thrive

Due to (or as a consequence of):

Stroke

Due to (or as a consequence of):

Diabetes Mellitus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

months

1 year

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pernicious anemia

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Medical Examiner  
Paul Schwartz MD

29c. License number

D17118

29d. Date signed (Month, Day, Year)

7/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Schwartz MD 115 E. McKee Ave 21212

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

Paula G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22221

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JEAN ADELL WILLEY</b>		2. Date of Death Month <b>JULY</b> Day <b>11</b> Year <b>1999</b>		3. Time of Death <b>6-40 PM</b>
	4a. Facility Name (If not Institution, give street and number) <b>NORTH ARUNDEL HOSPITAL</b>		4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>ANNE ARUNDEL</b>
Funeral Director	5. Social Security Number <b>363-03-1369</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>SEPT. 18, 1918</b>		9. Birthplace (State or Foreign Country) <b>KENTUCKY</b>		
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>HARUNDALE</b>	
10e. Street and Number <b>1919 NORMAN ROAD</b>		10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
17. Father's Name (First, Middle, Last) <b>EDWARD BINDSBURG</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ELLA ERWIN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>RONALD ARTHUR WILLEY (HUSBAND)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1919 NORMAN ROAD, GLEN BURNIE, MD. 21060</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park</b>		20c. Location - City or Town, State <b>Elkridge, Md.</b>	
21. Signature of Funeral Service Licensee <i>Michael C. Goffman</i>		22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>					Approximate Interval Between Onset and Death <b>4 DAYS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <i>Yal Shirazi, MD</i>		29c. License number <b>D 46962</b>		29d. Date signed (Month, Day, Year) <b>JULY 11, 1999</b>	
30. Name and address of person who completed cause of death (item 23e) (Type, Print) <b>M. SHIRAZI, M.D. NORTH ARUNDEL HOSPITAL. MD 21061.</b>					
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22222

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH CECELIA WHEELER</b>				2. Date of Death Month Day Year <b>JULY 11, 1999</b>		3. Time of Death <b>5:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>212-26-9736</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>FEB. 17, 1929</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>QUEEN ANNE'S</b>		10c. City, Town or Location <b>CHESTER</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1814 ST. MARY'S ROAD</b>				10f. Zip Code <b>21619</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>NELSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HICKS LUCY ECKMAN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>BERNARD WHEELER (HUSBAND)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1814 ST. MARY'S ROAD, CHESTER, MARYLAND 21619</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND VETERANS CEMETERY</b>		20c. Location - City or Town, State <b>CROWNSVILLE, MD.</b>		
21. Signature of Funeral Service Licensee <i>Michael C. Jaffar</i>				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>TENSION PNEUMOTHORAX</b> Due to (or as a consequence of): b. <b>RUPTURED PULMONARY BLEB</b> Due to (or as a consequence of): c. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>MINUTES</b> <b>2 HOURS</b> <b>YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CORONARY ARTERY DISEASE</b> <b>OSTEOPOROSIS WITH COMPRESSION FRACTURE</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Janie Harms</i>		29c. License number <b>041339</b>		29d. Date signed (Month, Day, Year) <b>JULY 12, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JANIE HARMS ANNE ARUNDEL MED. CTR. FRANKLIN + CATHEDRAL, ANNAPOLIS, MD</b>								
31. Date filed (Month, Day, Year) <b>JUL 14 1999</b>		32. Registrar's Signature <i>Sparks</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

*[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs, with some lines appearing as bold or indented. No specific words or phrases can be discerned.]*

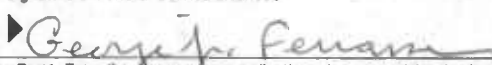


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22223

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNE PINCKNEY WEATHERLEY						2. Date of Death Month Day Year July 13, 1999		3. Time of Death 6:00 A.M.	
	4a. Facility Name (If not institution, give street and number) 509 Locksley Road						4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-03-9905		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) March 7, 1918		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 509 Locksley Road				10f. Zip Code 21204		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Richard Contee Rose						18. Mother's Name (First, Middle, Maiden Surname) Nina Didier				
19a. Informant's Name/Relationship (Type, Print) Joshua W. Weatherley (husband)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Locksley Road Towson, Maryland 21204				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 7-15-99		20c. Location - City or Town, State Pikesville, Maryland		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>RESPIRATORY FAILURE</u> Due to (or as a consequence of): b. <u>EMPHYSEMA</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  Attending				29c. License number D25538		29d. Date signed (Month, Day, Year) 7-13-99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter P. Stamas, MD 6565 N. Charles St S-462 Balto. MD 21204										
31. Date filed (Month, Day, Year) JUL 14 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22224

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cleo Washington

2. Date of Death

Month Day Year  
July 10 99

3. Time of Death

7:17 AM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hosp.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

213-32-8519

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
02-03-35

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2328 Barclay Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Health Aide

16b. Kind of Business/Industry

Baltimore City Sch.

17. Father's Name (First, Middle, Last)

Ballard

Emerson

18. Mother's Name (First, Middle, Maiden Surname)

Bertha

Farmer

19a. Informant's Name/Relationship (Type, Print)

Johnnie Washington

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2328 Barclay Street Baltimore, MD. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery 07-16-99 Anne Arundel Co.

Date

20c. Location - City or Town, State MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Baltimore, Maryland 21202  
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Glucose Intolerance

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Bronchitis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38026

29d. Date signed (Month, Day, Year)

7-13-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mark King, MD 201 E. University Pkwy Balto MD 21218

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

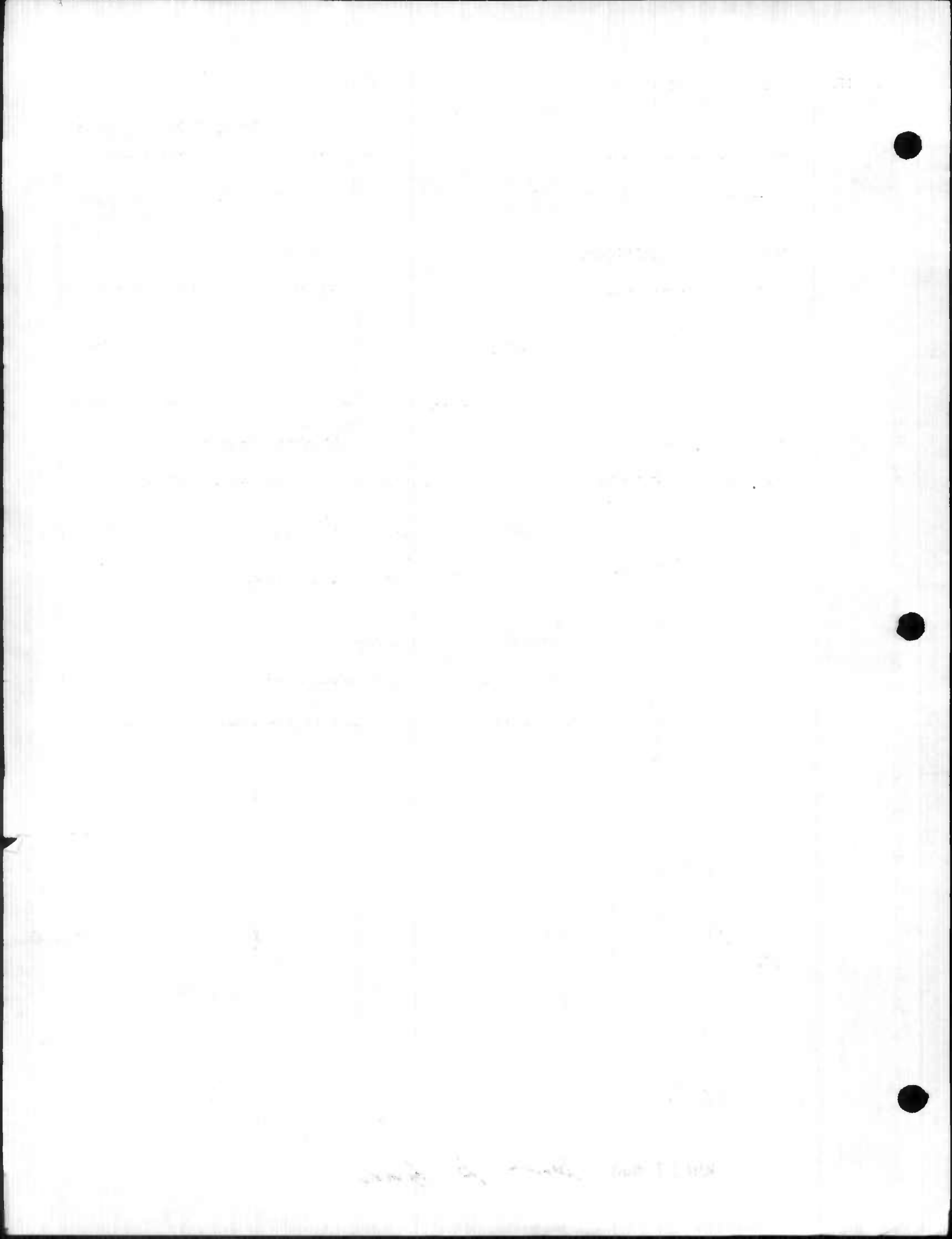
99 22225

AMEND ITEM: #26 PER MD G773 7-14-99 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Webb		2. Date of Death Month Day Year July 3, 1999		3. Time of Death 8:10 PM			
	4a. Facility Name (If not institution, give street and number) 7465 Manchester Road		4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 215-12-8260		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.			
	8. Date of Birth (Month, Day, Year) June 12, 1922		9. Birthplace (State or Foreign Country) Maryland					
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk			
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	10e. Street and Number 7465 Manchester Road		10f. Zip Code 21222		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
	14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker		16b. Kind of Business/Industry Manufacturing			
	17. Father's Name (First, Middle, Last) Charles W. Webb		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth McCracken					
	19a. Informant's Name/Relationship (Type, Print) Mrs. Ethel Webb/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7465 Manchester Road Dundalk, Maryland 21222					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee Johnny L. Stiles		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiomyopathy</i> Due to (or as a consequence of): b. <i>Valvular heart disease</i> Due to (or as a consequence of): c. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Hospice</i>					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Sallie Rixey	
	29c. License number AN9475941		29d. Date signed (Month, Day, Year) 7/6/99					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9101 Franklin Square Dr. Balto. MD 21237							
State Registrar	31. Date filed (Month, Day, Year) JUN 14 1999		32. Registrar's Signature Benjamin B. Sparks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22226

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>LOYE OTIS BOLYARD</b>				2. Date of Death Month Day Year <b>June 24, 1999</b>				3. Time of Death <b>2025 Hrs.</b>		
4a. Facility Name (If not institution, give street and number) <b>49 Locust Street</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>				4c. County of Death <b>Harford</b>		
5. Social Security Number <b>213-34-6722</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 11, 1937</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		
Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Havre de Grace</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>49 Locust Street</b>				10f. Zip Code <b>21078</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1957-58</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Material Handler</b>			16b. Kind of Business/Industry <b>Chemical</b>			
17. Father's Name (First, Middle, Last) <b>Ray Otis Bolyard</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Vauda (nmn) Stevenson</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Mattie L. Bolyard, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>49 Locust Street, Havre de Grace, Maryland 21078</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Memorial Gardens 6/29/99 Baltimore, Maryland</b>			Data		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ASCVD</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>n/a</b>			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>n/a</b>		28b. Time of Injury <b>n/a</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>n/a</b>		28d. Describe how injury occurred <b>n/a</b>		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>n/a</b>					28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>n/a</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>DMG</b>			29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>June 24 1999</b>			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Ganesh Prabhu, M.D. 218 Fulford Avenue, Bel Air, Maryland 21014</b>										
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22227

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Garvie James Cochran</b>				2. Date of Death Month Day Year <b>June 28, 1999</b>		3. Time of Death <b>2053</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>213-18-7518</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 17, 1917</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Darlington</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>P.O. Box 338</b>				10f. Zip Code <b>21034</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Highschool (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>		16b. Kind of Business/Industry <b>Agriculture</b>		
17. Father's Name (First, Middle, Last) <b>Spencer Cochran</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Inez Dixon</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ertie S. Cochran / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 338, Darlington, Maryland 21034</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>		Date <b>7-1-99</b>		20c. Location - City or Town, State <b>Bel Air, Maryland</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Acute Respiratory failure / Sepsis</b> Due to (or as a consequence of): <b>1 day</b>  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>S/P Knee Replacement</b> <b>Chronic Obstructive Pul Disease</b> <b>Polyarthrosis</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier <b>MIRZA A-BAG MD</b>		29c. License number <b>D43115</b>		29d. Date signed (Month, Day, Year) <b>6-29-99</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MIRZA A. BAG 615 S-Union Ave, Havre de Grace, MD</b>								
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22228

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NORRIS L. CAIN, SR.

2. Date of Death

Month

Day

Year

June 25, 1999

3. Time of Death

5:45 P.M.

4e. Facility Name (If not institution, give street and number)

212 Maple Avenue

4b. City, Town, or Location of Death

Federalsburg

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

213-24-0935

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 20, 1929

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

212 Maple Avenue

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking

17. Father's Name (First, Middle, Last)

Earley Cain

18. Mother's Name (First, Middle, Maiden Surname)

Clara Crocker

19e. Informant's Name/Relationship (Type, Print)

Rhonda B. Cain/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

212 Maple Ave., Federalsburg, MD 21632

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Md. Anatomy Board

Date

6/25

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home, PA  
P.O. Box 43 Federalsburg, MD 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Prostate cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28e. Date of injury

(Month, Day, Year)

28b. Time of

injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

David Smith

29c. License number

D39887

29d. Date signed (Month, Day, Year)

7/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Smith, M.D., 29466 Pintail Dr., Easton, MD 21601

31. Date filed (Month, Day, Year)

JUL 01 1999

32. Registrar's Signature

James B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



99 22229

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Thomas Dean, Sr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>June 30 1999</b>		3. TIME OF DEATH <b>7:25 AM</b>	
4. SOCIAL SECURITY NUMBER <b>214-32-6589</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 4, 1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>18870 Crown Stone Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Marydel</b>	
9c. COUNTY OF DEATH <b>Caroline</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Caroline</b>	
10c. CITY, TOWN OR LOCATION <b>Denton</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>25139 Adams Landing Road</b>	
10f. ZIP CODE <b>21629</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 HS Grad.</b> College (1-4 or 5+) <b>5</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Agriculture</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert Garey Dean</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Rosemond Jones</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert Dean Son</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18870 Crown Stone Road, Marydel, Maryland 21649</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Denton Cemetery</b>		20c. LOCATION — City or Town, State <b>Denton, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul P. Moore</i>				22. NAME AND ADDRESS OF FACILITY <b>Moore Funeral Home, P.A.</b> <b>12 South Second Street, Denton, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal Failure</b>							
DUPLICATE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUPLICATE TO (OR AS A CONSEQUENCE OF): <b>Compensatory Heart Failure</b>							
DUPLICATE TO (OR AS A CONSEQUENCE OF): <b>Aortic Stenosis + Ischemic Cardio-myopathy</b>							
DUPLICATE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D42816</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/2/99</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>607 Dutchmans Lane Easton, MD 21601</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 02 1999</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MEO 6773-7-12-99-WB

Certificate of Death

Reg. No.

99 22230

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Brenda Ann Creel				2. Date of Death Month Day Year June 14, 1999				3. Time of Death 11:45 A.M.						
	4a. Facility Name (If not institution, give street and number) Glen Cove Marina				4b. City, Town, or Location of Death Darlington				4c. County of Death Harford						
Funeral Director	5. Social Security Number 215-76-1332		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 07/24/1960		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent														
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 900 Rosedale Avenue				10f. Zip Code 21061				10g. Citizen of What Country? United States							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager				16b. Kind of Business/Industry Entertainment							
17. Father's Name (First, Middle, Last) John Maurice Warch				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Jane McCoy											
19a. Informant's Name/Relationship (Type, Print) John Maurice Warch (Father)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Rosedale Avenue, Glen Burnie, MD 21061											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC				Date 6/21/99		20c. Location - City or Town, State Stevensville, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Ave. S.W. Glen Burnie, Maryland 21061											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. DROWNING Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COCAINE ABUSE															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene											
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) Found: 6-14-99		28b. Time of Injury Found: 9-10		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT DROWNED					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN WATER				28f. Location (Street and Number or Rural Route Number, City or Town, State) GLEN COVE MARINA DARLINGTON, MARYLAND											
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier 				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) June 15, 1999							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) JUN 23 1999				32. Registrar's Signature 											

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Handwritten signature and date: JUN 3 1988



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

7-14-99

Certificate of Death

Reg. No.

99 22231

ITEMS: #23 PART 1, 27, 28A-F PER MEO G773

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Jane Forrester

2. Date of Death

Month Day Year

May 12, 1999

3. Time of Death

9:34 A.M.

4a. Facility Name (If not institution, give street and number)

7 Kafern Court

4b. City, Town, or Location of Death

Gwynn Oak

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-11-7724

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

13

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 30, 1985

9. Birthplace (State or Foreign Country)

Chestertown, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

25325 Chestertown Road

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Larry Francis Forrester

18. Mother's Name (First, Middle, Maiden Surname)

Rose Marie Forrester

19a. Informant's Name/Relationship (Type, Print)

Rose Marie Forrester/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25325 Chestertown Road, Chestertown, MD 21620

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Cremation Center, LLC 7/1/99

Date

20c. Location - City or Town, State

Stevensville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.  
130 Speer Road, Chestertown, Maryland 2162023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. BLUNT FORCE INJURIES OF THE HEAD AND STAB WOUNDS OF CHEST

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

at scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)Found:  
5-12-9928b. Time of  
InjuryFound:  
8:00

A

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT WAS BEATEN AND STABBED

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

WOODS

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

7 KAFERN COURT, GWYNN OAK, BALTIMORE

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. CO MD  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 06 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



99 22232

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Paul Anderson Gleaton, Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 1 1999</b>		3. TIME OF DEATH <b>1:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>220-52-0978</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>February 9, 1949</b>	
8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1513 Snow Hill Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Stockton</b>	
9c. COUNTY OF DEATH <b>Worcester</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>	
10c. CITY, TOWN OR LOCATION <b>Stockton</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1513 Snow Hill Road</b>	
10f. ZIP CODE <b>21864</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Vietnam War</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Wood Carver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Crafts</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Paul Anderson Gleaton, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rebecca Elizabeth Chavis</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Paul A. Gleaton, Sr. Father</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO Box 25, Stockton, Maryland 21864</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Capitol Crematory</b>		DATE <b>7/2</b>		20c. LOCATION — City or Town, State <b>Dover, Delaware</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randolph P. Moore</i>				22. NAME AND ADDRESS OF FACILITY <b>Moore Funeral Home, P.A.</b> <b>12 South Second Street, Denton, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Renal Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>Months</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Sikes MD</i>				29c. LICENSE NUMBER <b>D31376</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-1-99</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James Sikes 920 Market St Denton MD 21629</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 01 1999</b>				32. REGISTRAR'S SIGNATURE <i>Barbara B. Sparks</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22233

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Lou Jordan

2. Date of Death

Month  
June

Day  
28

Year  
1999

3. Time of Death

11:20 A.M.

4a. Facility Name (If not institution, give street and number)

312 Worthington Court

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

169-26-6380

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 21, 1932

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

312 Worthington Court

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In home

17. Father's Name (First, Middle, Last)

Darrel G. Turner

18. Mother's Name (First, Middle, Maiden Surname)

Nora Mildred Bigler

19a. Informant's Name/Relationship (Type, Print)

Carl M. Jordan (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

312 Worthington Ct., Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gardens

Date

7/1/99

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

*Kenneth B. Bayne*

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *NON-SMALL CELL LUNG CANCER*

Approximate Interval Between Onset and Death

*3 YEARS*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. \_\_\_\_\_  
Dua to (or as a consequence of):

c. \_\_\_\_\_  
Dua to (or as a consequence of):

d. \_\_\_\_\_  
Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Joan P. Edwards MD*

29c. License number

*D31775*

29d. Date signed (Month, Day, Year)

*JUNE 29, 1999*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*JOAN P. EDWARDS, MD*

*2112 BELAIR ROAD  
FAUSTON, MARYLAND*

*21047*

31. Date filed (Month, Day, Year)

*JUN 29 1999*

32. Registrar's Signature

*Joan P. Edwards*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22234

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Lemuel Kendall				2. Date of Death Month Day Year June 27, 1999				3. Time of Death 1845	
	4a. Facility Name (If not institution, give street and number) 4976 Skinners Neck Road (Residence)				4b. City, Town, or Location of Death Rock Hall				4c. County of Death Kent	
Funeral Director	5. Social Security Number 215-26-5477		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) January 15, 1930		9. Birthplace (State or Foreign Country) Rock Hall, MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Rock Hall				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 4976 Skinners Neck Road				10f. Zip Code 21661		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1947-1952		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waterman			16b. Kind of Business/Industry Seafood		
	17. Father's Name (First, Middle, Last) Charles Nelson Kendall				18. Mother's Name (First, Middle, Maiden Surname) Enia Mae Beck					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Leona Elizabeth Kendall/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4976 Skinners Neck Road, Rock Hall, MD 21661					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Chapel Cemetery		Date 7/1/99		20c. Location - City or Town, State Rock Hall, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number 12-13824		29d. Date signed (Month, Day, Year) 6-28-99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Seymour, 122 Speer Road, Suite 5, Chestertown, Maryland 21620									
31. Date filed (Month, Day, Year) JUN 29 1999		32. Registrar's Signature 								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

AMEND ITEM #1 PER DR. G773 7-16-99 J.A.

22235

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMORY L. KLINE <del>KLINE, EMORY</del> JR.				2. Date of Death Month Day Year JUNE THIRTIETH 1999		3. Time of Death 1130											
	4a. Facility Name (If not institution, give street and number) BALTIMORE V.A. MEDICAL CENTER; 10 N GREENE ST				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY											
Funeral Director	5. Social Security Number 217 16 2446	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOVEMBER 14, 1923	9. Birthplace (State or Foreign Country) Maryland											
	Usual Residence of Decedent																	
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No												
10e. Street and Number 5740 Charstone Court				10f. Zip Code 21703		10g. Citizen of What Country? U.S.A.												
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Fred. Iron & Steel												
17. Father's Name (First, Middle, Last) Emory L. Kline, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Crone														
19a. Informant's Name/Relationship (Type, Print) Elinor Kline (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5740 Charstone Court, Frederick, MD 21703														
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens		Date 7/3/99		20c. Location - City or Town, State Frederick, Maryland												
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>SEPSIS</td> <td rowspan="4">           Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death             14             28             months         </td> </tr> <tr> <td>b.</td> <td>BOWEL PERFORATION</td> </tr> <tr> <td>c.</td> <td>CARCINOMATOSIS</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	SEPSIS	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  14  28  months	b.	BOWEL PERFORATION	c.	CARCINOMATOSIS	d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	SEPSIS	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  14  28  months														
	b.	BOWEL PERFORATION																
	c.	CARCINOMATOSIS																
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown												
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
		28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number P10000		29d. Date signed (Month, Day, Year) June, 30, 1999												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. R. ROYAL 22 SOUTH GREENE STREET, BALTIMORE MD 21201																		
31. Date filed (Month, Day, Year) JUL 02 1999		32. Registrar's Signature 																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified in writing.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



99 22236

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Dallas Gross Lord</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 3 1999</b>		3. TIME OF DEATH M <b>10:35 AM</b>	
4. SOCIAL SECURITY NUMBER <b>215-26-3919</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>December 27, 1929</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>8141 Harmony Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Denton</b>		9c. COUNTY OF DEATH <b>Caroline</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Caroline</b>		10c. CITY, TOWN OR LOCATION <b>Denton</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8141 Harmony Road</b>				10f. ZIP CODE <b>21629</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 HS Grad.</b> College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Trucking</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles C. Lord</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Gross</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen M. Lord</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Wife 8141 Harmony Road, Denton, Maryland 21629</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Concord Cemetery 7/7</b>		20c. LOCATION — City or Town, State <b>Denton, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randolph Moore</i>		22. NAME AND ADDRESS OF FACILITY <b>Moore Funeral Home, P.A. 21629</b> <b>12 South Second Street, Denton, Maryland</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic colon cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>3 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David Smith</i>				29c. LICENSE NUMBER <b>D37887</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/8/99</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David Smith, M.D., 29466 Pin Tail Drive, Easton, Maryland 21601</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 08 1999</b>		32. REGISTRAR'S SIGNATURE <i>Renée B. Sparks</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22237

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edward Merritt Leiby</b>				2. Date of Death Month <b>June</b> Day <b>27</b> Year <b>1999</b>		3. Time of Death <b>1500</b>	
	4a. Facility Name (If not institution, give street and number) <b>The Kent and Queen Anne's Hospital, Inc.</b>				4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Kent</b>	
Funeral Director	5. Social Security Number <b>215-36-0285</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 7, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>Church Hill, MD</b>							
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Kent</b>		10c. City, Town or Location <b>Chestertown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>24295 Langford Road</b>				10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farming</b>			16b. Kind of Business/Industry <b>Agriculture</b>		
17. Father's Name (First, Middle, Last) <b>Edward Daniel Leiby</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude White</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Trudy Zimmerman/Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8505 Broadneck Road, Chestertown, MD 21620</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Pauls Cemetery</b>		Date <b>6/30/99</b>		20c. Location - City or Town, State <b>Chestertown, MD</b>	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Due to (or as a consequence of): <b>Aspiration</b> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Trauma fall</b> Due to (or as a consequence of):   Approximate Interval Between Onset and Death <b>5 days</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multiple CVA / @ Houd diaphragm Paralysis / CAD<sub>3</sub> / SP CABG COPD / AFib / ASCVD<sub>3</sub> / Hx MI / DJD Hx GLE Bleeding.</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>D50996</b>		29d. Date signed (Month, Day, Year) <b>4/28/99</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Neil Stoddard 100 Brown St. Chestertown MD 21620</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

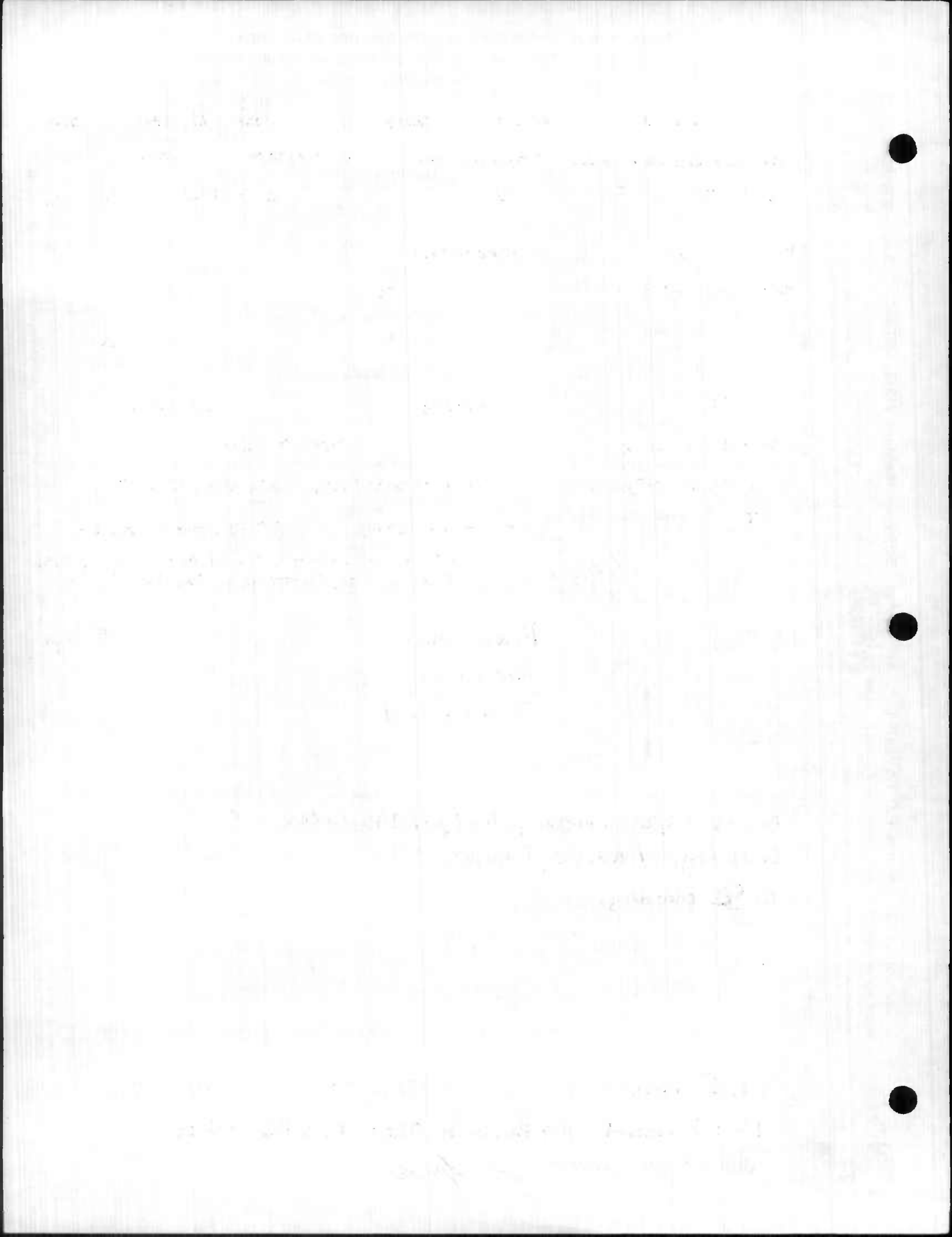
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22238

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Helen Alda Myers

2. Date of Death

June 30, 1999

3. Time of Death

7:04 AM

4a. Facility Name (If not institution, give street and number)

ER Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

220-14-1618

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 24, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inalde City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1409 Saratoga Drive

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Public Education

17. Father's Name (First, Middle, Last)

John Adam Wolff

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Alda Randall

19a. Informant's Name/Relationship (Type, Print)

Emil H. Myers / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1409 Saratoga Dr., Bel Air, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Trinity Lutheran Church Cem.

Date

7-3-99

20c. Location - City or Town, State

Joppa, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 2100923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

ASCVD

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

DME

29c. License number

OCME

29d. Date signed (Month, Day, Year)

June 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G.S. Prabhu M.D. 218 Fulford Ave Bel Air MD. 21014 410-879-6564.

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

7000 0 0 0000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22239

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frank Mischczuk</b>				2. Date of Death Month Day Year <b>June 26 1999</b>				3. Time of Death <b>12:42 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>				4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>213-16-9423</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>76 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Feb. 12, 1923</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent				10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>201 Plaza Ct. Apt. 2-B</b>				10f. Zip Code <b>21001</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meat packing</b>				16b. Kind of Business/Industry <b>Esskay Meat Co.</b>			
17. Father's Name (First, Middle, Last) <b>Michael Mischczuk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maryanna UNK</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Doris Mischczuk (Spouse)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>201 Plaza Ct., Apt. 2-B, Aberdeen, MD 21001</b>							
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery</b>			20c. Date <b>6/30/99</b>		20d. Location - City or Town, State <b>Baltimore, MD</b>			
21. Signature of Funeral Service Licensee <i>Timothy B. Cargis</i>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>pneumonia</b>										Approximate Interval Between Onset and Death <b>4 DAYS</b>	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ARDS (Adult respiratory Distress syndrome)</b>										23c. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>	
24a. Was an autopsy performed? <b>1 Yes 2 No</b>										24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Charles Eck</i> MD				29c. License number <b>D31712</b>		29d. Date signed (Month, Day, Year) <b>6/28/99</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>CHARLES ECK JR 219 W. BELAIR AVE. ABERDEEN, MD 21001</b>											
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>				32. Registrar's Signature <i>Barbara B. Spahr</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5x1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22240

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hilda Elizabeth Maloney</b>				2. Date of Death Month <b>07</b> Day <b>02</b> Year <b>99</b>		3. Time of Death <b>9:15PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CAROLINE NURSING HOME, INC.</b>				4b. City, Town, or Location of Death <b>DENTON</b>		4c. County of Death <b>CAROLINE</b>	
Funeral Director	5. Social Security Number <b>216-40-3456</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 29, 1909</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Caroline</b>	10c. City, Town or Location <b>Denton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>24594 Williston Road</b>				10f. Zip Code <b>21629</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cafeteria worker</b>				16b. Kind of Business/Industry <b>Food Services in Education</b>	
	17. Father's Name (First, Middle, Last) <b>William Emmett Lord</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosa Agnes Weaver</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ruth Ann Blazejak Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 South First Street, Denton, Maryland 21629</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Concord Cemetery</b>		Date <b>7/6/99</b>		20c. Location - City or Town, State <b>near Denton, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Randolph P. Moore</b>				22. Name and Address of Facility <b>Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629</b>			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Multiinfarct Dementia</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>year</b>							
	23f. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  {							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>James Sikes MD</b>		29c. License number <b>D31376</b>		29d. Date signed (Month, Day, Year) <b>7-5-99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>James Sikes 920 Market St Denton MD 21629</b>								
31. Date filed (Month, Day, Year) <b>JUL 08 1999</b>		32. Registrar's Signature <b>B. Adams</b>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22241

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Clayton Quillen

2. Date of Death

Month Day Year  
07 04 99

3. Time of Death

11:13 a.m.

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home, Inc.

4b. City, Town, or Location of Death

Denton, Maryland

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

216-38-9959

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 2, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

107 Randolph Street

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

John Harvey Quillen

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Thawley

19a. Informant's Name/Relationship (Type, Print)

Peggy Blades Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10819 Greensboro Road, Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Denton Cemetery

Date

7/7/99

20c. Location - City or Town, State

Denton, Maryland

21. Signature of Funeral Service Licensee

► Randolph P. Moore

22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

bronchial pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Wafik M.D.

29c. License number

047534

29d. Date signed (Month, Day, Year)

7/4/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wafik Zaki, M.D., PO Box 496, Denton, Maryland 21629

31. Date filed (Month, Day, Year)

JUL 08 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended 6-30-99 Certificate of Death

Reg. No.

99 22242

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES LOTAN RASIN, SR.</b>				2. Date of Death Month Day Year <b>June 26, 1999</b>		3. Time of Death <b>10:40 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>103 Charlotte Avenue</b>				4b. City, Town, or Location of Death <b>Federalsburg</b>		4c. County of Death <b>Caroline</b>		
Funeral Director	5. Social Security Number <b>212-28-5036</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Oct. 13, 1931</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Federalsburg</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>103 Charlotte Avenue</b>		10f. Zip Code <b>21632</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mill Wright/Mech. Tech.</b>		16b. Kind of Business/Industry <b>Bethlehem Steel</b>		17. Father's Name (First, Middle, Last) <b>Lotan Holland Rasin</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Hoblitz Rasin</b>	
19a. Intoment's Name/Relationship (Type, Print) <b>Betty Rasin/Spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>103 Charlotte Ave., Federalsburg, MD 21632</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Junior Order Cem.</b>		20c. Location - City or Town, State <b>6/30 Preston, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Michael F. Esken</b>		22. Name and Address of Facility <b>Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CONTACT GUNSHOT WOUND OF CHEST</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>6-26-99</b>		28b. Time of Injury <b>5:45 P.M.</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SHOOTER SHOT SELF.</b>		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) <b>RESIDENCE</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>103 CHARLOTTE AVE CAROLINE CO MD</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Wayne Melville</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>June 27, 1999</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARYANN A. KORELL MD 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature <b>Barbara B. Sparks</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22243

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSEMARIE E. RASIN</b>				2. Date of Death Month Day Year <b>June 26, 1999</b>		3. Time of Death <b>10:40 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>103 Charlotte Avenue</b>				4b. City, Town, or Location of Death <b>Federalsburg</b>		4c. County of Death <b>Caroline</b>	
Funeral Director	5. Social Security Number <b>219-62-4421</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>44 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept 2, 1954</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Federalsburg</b>			10d. Inside City Limits <b>1 X Yes 2 No</b>	
10e. Street and Number <b>103 Charlotte Avenue</b>				10f. Zip Code <b>21632</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <b>1 X Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 X No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Worker</b>			16b. Kind of Business/Industry <b>Pewter Production</b>	
17. Father's Name (First, Middle, Last) <b>Charles Lotan Rasin, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Betty Dibbern</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Betty D. Rasin/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>103 Charlotte Ave., Federalsburg, MD 21632</b>				
20a. Method of Disposition <b>1 X Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Junior Order Cem.</b>		Date <b>6/30</b>		20c. Location - City or Town, State <b>Preston, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Mutual 7. Egan</b>				22. Name and Address of Facility <b>Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Gunshot wound of head</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 X No 3 Probably 4 Unknown</b>
								24a. Was an autopsy performed? <b>1 X Yes 2 No</b>
								24b. Were autopsy findings available prior to completion of cause of death? <b>1 X Yes 2 No</b>
25. Was case referred to medical examiner? <b>1 X Yes 2 No</b>				26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 X Residence 6 Other (Specify)</b>				
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending Investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>6-26-99</b>		28b. Time of Injury <b>5:45 AM</b>		28c. Injury at Work? <b>1 Yes 2 X No</b>		28d. Describe how injury occurred <b>SHOTS WERE SHOT.</b>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>RESIDENCE</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>103 CHARLOTTE AVE CAROLINE CO, MD</b>				
29e. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>								
29b. Signature and title of certifier <b>Katherine M. Kue</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>June 27, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYLAND P. KOREN M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature <b>Beanna B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22244

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Donald Wayne Strouth

2. Date of Death

Month Day Year

June 27 1999

3. Time of Death

5:08 A.M.

4a. Facility Name (If not institution, give street and number)

425 Keene Drive

4b. City, Town, or Location of Death

Perryman

4c. County of Death

Harford

5. Social Security Number

230-42-8014

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 23, 1935

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Perryman

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

425 Keene Drive

10f. Zip Code

21130

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Carpenter

17. Father's Name (First, Middle, Last)

John W. Strouth

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Clemmons

19a. Informant's Name/Relationship (Type, Print)

Geraldine Strouth (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

425 Keene Drive, Perryman, Maryland 21130

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

7/1/99

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Kristen Arnesen

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip W. Halstead

29c. License number

D50803

29d. Date signed (Month, Day, Year)

6/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1200 BRASS MINE RD, BELLEVILLE, MD 21017 PHILIP HALSTEAD, MD

31. Date filed (Month, Day, Year)

JUN 29 1999

32. Registrar's Signature

B. Spotts

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

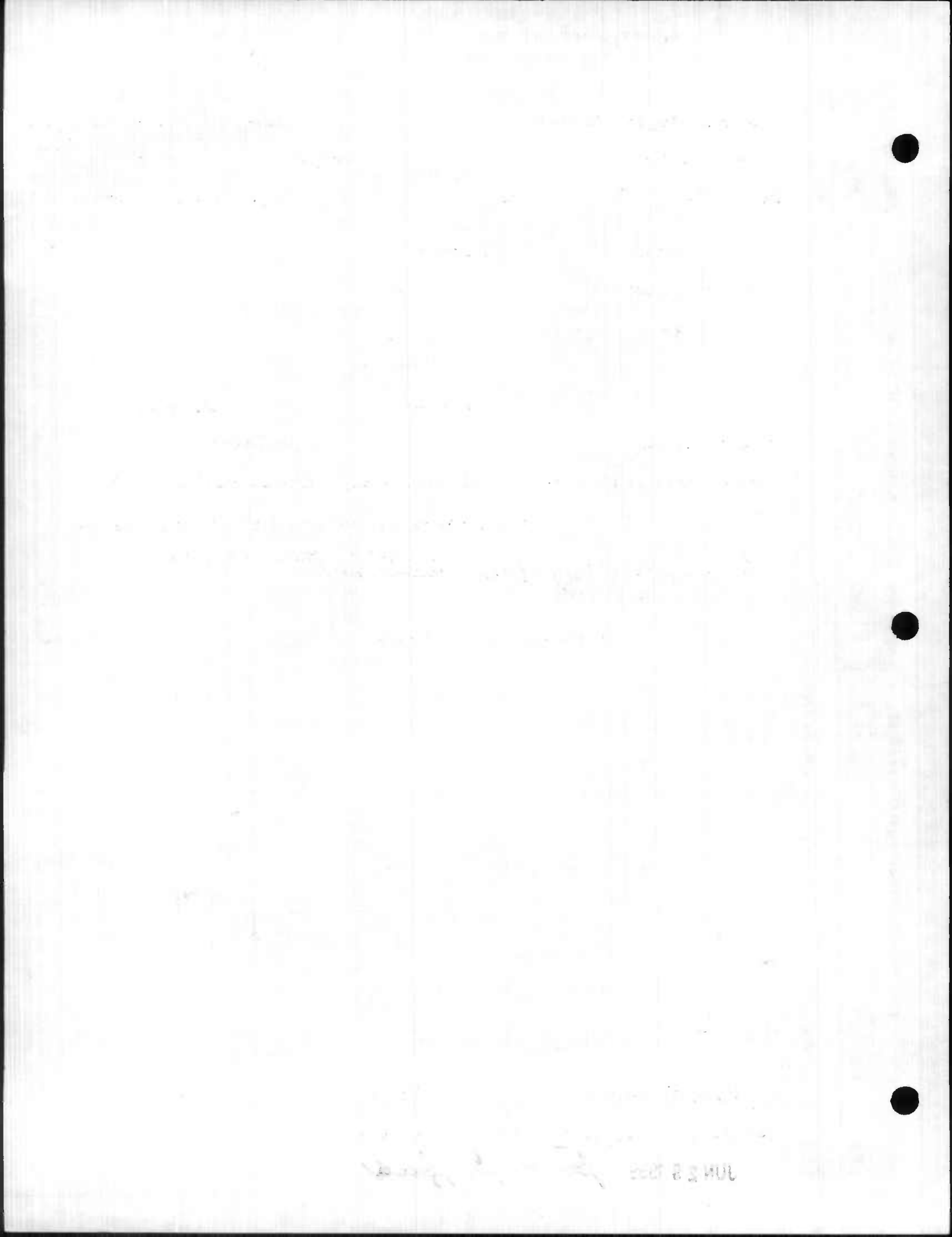
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22245

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Warren Allen Sauble Sr					2. Date of Death Month Day Year June 25, 1999			3. Time of Death 6:53 A.M.						
	4a. Facility Name (If not institution, give street and number) Easton Memorial Hospital					4b. City, Town, or Location of Death Easton			4c. County of Death Talbot						
Funeral Director	5. Social Security Number 215-40-9993		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) Sept 14, 1942		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent					10a. State Maryland		10b. County Caroline		10c. City, Town or Location Goldsboro					
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					10e. Street and Number 15040 Day Rd		10f. Zip Code 21636		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipping Supervisor			16b. Kind of Business/Industry Box Manufacturing						
	17. Father's Name (First, Middle, Last) Ernest Michael Sauble					18. Mother's Name (First, Middle, Maiden Surname) Elenora Schoff									
	19a. Informant's Name/Relationship (Type, Print) Margaret Sauble Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15040 Day Rd Goldsboro, Maryland 21636									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Greensboro Cemetery		20c. Location - City or Town, State 6-28-99 Greensboro, Maryland							
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Fleegle & Helfenbein Funeral Home, P.A.									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic cardiovascular disease</u> Due to (or as a consequence of): b. <u>Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 26, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Margaret Sauble</u> 111 Penn Street, Baltimore, Maryland 21201															
State Registrar	31. Date filed (Month, Day, Year) JUN 29 1999					32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22246

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Larry Dale Taylor, Sr.</b>				2. Date of Death Month <b>June</b> Day <b>25</b> Year <b>1999</b>		3. Time of Death <b>1715</b>
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>
Funeral Director	5. Social Security Number <b>217-50-7003</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 16, 1950</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent						
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>19 E. Inca Street</b>				10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>		16b. Kind of Business/Industry <b>N/A</b>	
17. Father's Name (First, Middle, Last) <b>Claud E. Taylor</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mae Ellis</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Linda Taylor (Spouse)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19 E. Inca St., Aberdeen, MD 21001</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Grove Presbyterian Cemetery</b>		Date <b>6/29/99</b>		20c. Location - City or Town, State <b>Aberdeen, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Husker Ampley</b>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (First disease or condition resulting in death) <b>a. EMPHYSEMA</b> Due to (or as a consequence of): <b>b. DILATED CARDIOMYOPATHY</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>&gt; 10 yrs</b> <b>&gt; 5 yrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL INSUFFICIENCY</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier <b>Claudia A. Kroken</b>		29c. License number <b>DS0040</b>		29d. Date signed (Month, Day, Year) <b>06-26-99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CLAUDIA A. KROKEN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040</b>							
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature <b>B. Sparks</b>					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



VanSant, Edith  
4/3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22247

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Edith Allen VanSant		2. Date of Death Month Day Year June 29, 1999		3. Time of Death 4:00 p.m.	
4a. Facility Name (If not institution, give street and number) Chestertown Nursing & Rehab. Center		4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
5. Social Security Number 220-52-8353	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 104 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 20, 1894
9. Birthplace (State or Foreign Country) Maryland					
10e. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 415 Morgnec Road		10f. Zip Code 21620		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) George VanSant		18. Mother's Name (First, Middle, Maiden Surname) Julia McGinnes			
19a. Informant's Name/Relationship (Type, Print) Kent Wharton/Nephew		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34275 Delaware Line Road, Golts, MD 21635			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crumpton Cemetery		20c. Location - City or Town, State 7/3/99 Crumpton, Maryland	
21. Signature of Funeral Service Licensee <i>Frank J. Helfenbein</i>		22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Respiratory arrest</u> Due to (or as a consequence of):  b. <u>Aspiration pneumonia</u> Due to (or as a consequence of):  c. <u>Bowel Obstruction</u> Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 minute 1 day 1 week	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>End stage Dementia</u>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>YS</i> MD		29c. License number D51735		29d. Date signed (Month, Day, Year) 6/30/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Delboy, M.D., 6602 Church Hill Road, Suite 200, Chestertown, MD 21620					
31. Date filed (Month, Day, Year) JUN 30 1999		32. Registrar's Signature <i>B. Sparks</i>			

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22248

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marie Katherine Wetzel</b>				2. Date of Death Month Day Year <b>JUNE 29 1999</b>		3. Time of Death <b>11:30AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Bel Air</b>				4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>215-05-0722</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 29, 1915</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Harford</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>2910 Strathaven Ln.</b>		10f. Zip Code <b>21009</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesperson</b>		16b. Kind of Business/Industry <b>Retail</b>			
	17. Father's Name (First, Middle, Last) <b>Henry Milton Bankard</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine (u/k) McGinty</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara A. Rovine / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2910 Strathaven Ln., Abingdon, MD 21009</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens 7-1-99 Bel Air, Maryland</b>		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>Stephen A. Murphy</i>		22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>					
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Congestive Heart Failure</b></p> <p>b. <b>Ischemic Cardiomyopathy</b></p> <p>c. </p> <p>d. </p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>1 week</b></p> <p><b>5 years</b></p> </div> </div>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>MD</i>		29c. License number <b>D34652</b>		29d. Date signed (Month, Day, Year) <b>June 30, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Scott Haswell 2 North Avenue Bel Air Maryland 21014</b>								
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22249

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Henry Allen Jr.</b>				2. Date of Death Month <b>July</b> Day <b>14</b> Year <b>1999</b>		3. Time of Death <b>2:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Elder Care</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-68-4496</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>42</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 8, 1957</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State <b>MD</b>		10b. County <b>Prince Georges</b>		10c. City/Town or Location <b>Accokeek</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>15817 Blackburn St.</b>				10f. Zip Code <b>20607</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>AFRICAN AMERICAN</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (11-14 or 15+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>ERECTION</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Henry Allen Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Carter</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Tonyie L. Allen Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3111 Ripple Road Randallstown, MD 21244</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESTERN STAR</b>		Date <b>7/19/99</b>		20c. Location - City or Town, State <b>CATONSVILLE, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Albert P. Wylie F/H PA 21217 638 N. Guilford St., BALTIMORE, MD</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>HIV</b>								Approximate Interval Between Onset and Death <b>1/25</b>
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>VIRAL CEREBRITIS</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D20333</b>		29d. Date signed (Month, Day, Year) <b>7/15/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K ZONIELAND 1838 GREENTREE RD PIKEVILLE MD</b>								
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>				32. Registrar's Signature 				

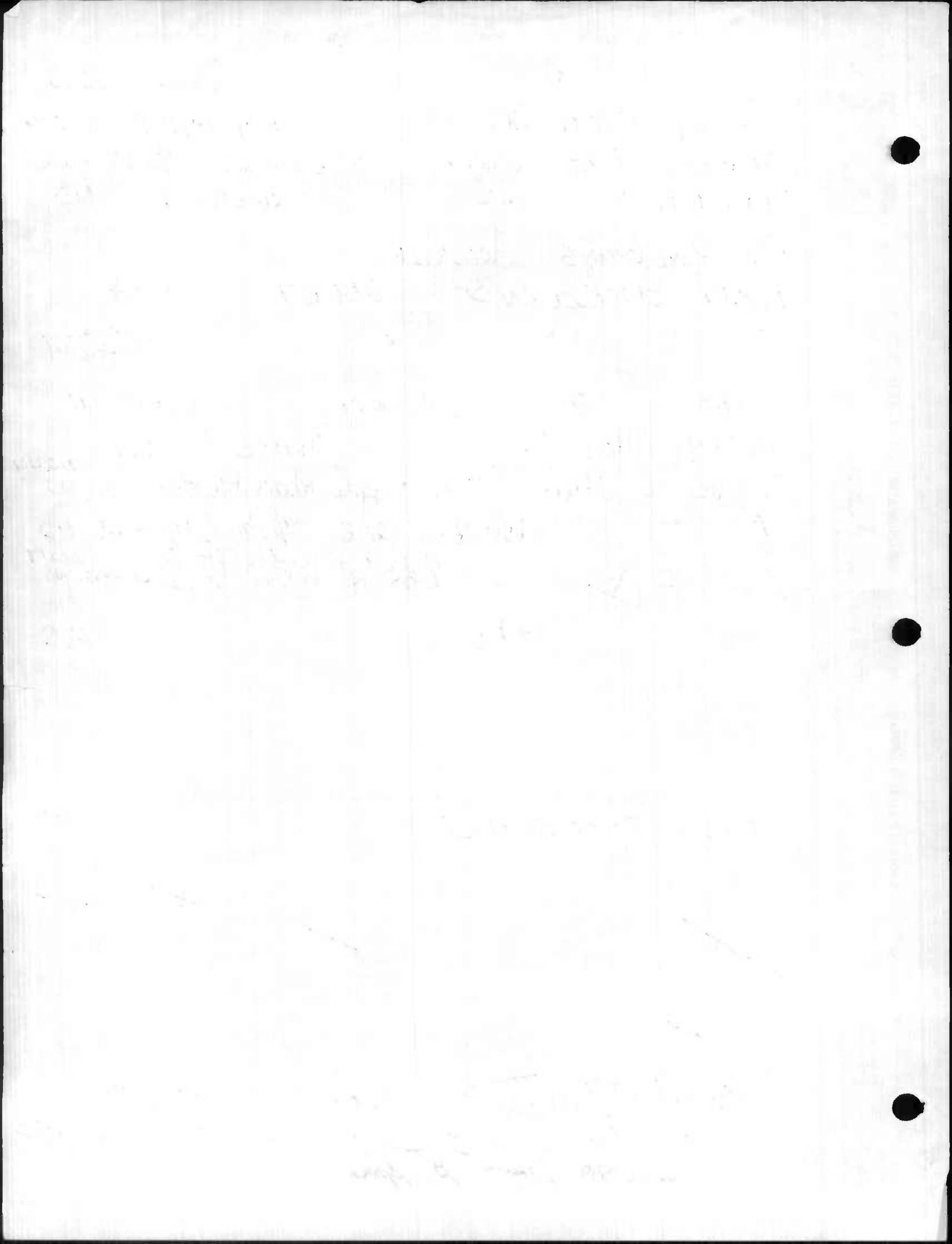
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#18 perFH G773 7/16/99EW  
AMEND ITEMS: #10A-F, 20C PER F.H. G773 7-15-99 WR.

State of Maryland / Department of Health and Mental Hygiene

99 22250

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Gerda Avery</i>				2. Date of Death Month <i>July</i> Day <i>11</i> Year <i>1999</i> 9:30 AM				3. Time of Death <i>9:30 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Vantage House</i>				4b. City, Town, or Location of Death <i>Columbia</i>				4c. County of Death <i>Howard</i>	
Funeral Director	5. Social Security Number <i>114-07-3876</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <i>92</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <i>APR. 21, 1907</i>		9. Birthplace (State or Foreign Country) <i>GERMANY</i>		10a. State <i>NY</i>		10b. County <i>WESTCHESTER</i>		10c. City, Town or Location <i>HOWARD</i>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>NY</i> 10b. County <i>WESTCHESTER</i> 10c. City, Town or Location <i>HOWARD</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <i>5400 VANTAGE POINT ROAD</i>	
	10f. Zip Code <i>21044</i>				10g. Citizen of What Country? <i>U.S.A.</i>				10h. Street and Number <i>244 GRAND VIEW BOULEVARD</i>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOUSEWIFE</i>		16b. Kind of Business/Industry <i>OWN HOME</i>		17. Father's Name (First, Middle, Last) <i>MAX MASCHKOWSKI</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>OLGA Lewandowski LEWANOWSKI</i>		19a. Informant's Name/Relationship (Type, Print) <i>TOM AVERY / SON</i>	
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>244 GRAND VIEW BLVD. - YONKERS, NY 10710</i>				20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MT. HOPE CEMETERY</i>		20c. Location (City or Town, State) <i>HASTINGS ON HUDSON NY</i>	
	21. Signature of Funeral Service Licensee <i>Scott M. Cutler</i>				22. Name and Address of Facility <i>SOL LEVINSON &amp; BROS., INC.</i> <i>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Aortic Stenosis</i>		Approximate Interval Between Onset and Death <i>5 years</i>	
To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i>				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
To Be Completed by Physician/Medical Examiner	28b. Time of Injury <i>M</i>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Michelle Price M.D.</i>		29c. License number <i>050778</i>		29d. Date signed (Month, Day, Year) <i>July 11, 1999</i>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michelle Price 11035 Little Patuxent Pkwy Columbia, MD 21044</i>				31. Date filed (Month, Day, Year) <i>JUL 15 1999</i>		32. Registrar's Signature <i>Benita B. Sparks</i>		33. Date of Death <i>July 11, 1999</i>	
	34. Date of Death <i>July 11, 1999</i>				35. Date of Death <i>July 11, 1999</i>		36. Date of Death <i>July 11, 1999</i>		37. Date of Death <i>July 11, 1999</i>	

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22251

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GLORIA BURKETT</b>				2. Date of Death Month Day Year <b>JULY 10 1999</b>		3. Time of Death <b>11 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>CARROLL COUNTY GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>WESTMINSTER</b>		4c. County of Death <b>CARROLL</b>		
Funeral Director	5. Social Security Number <b>212-26-5767</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB 11, 1928</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>20 SHEPPARD Lane</b>		10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHER</b>		16b. Kind of Business/Industry <b>Baltimore City Public Schools</b>		17. Father's Name (First, Middle, Last) <b>William E. Colona</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Hill</b>		19. Intendant's Name/Relationship (Type, Print) <b>Nancy B. Vaughn / Daughter</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakeview Memorial Park</b>		20c. Location - City or Town, State <b>7/17/99 Sykesville, Md</b>		21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>CHAPMAN - HARRIS F.H. 5240 REISTERSTOWN ROAD Baltimore, Md 21215</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MYOCARDIAL INFARCTION</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>	
29c. License number <b>D37333</b>		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C. RAVI MD, NHC, BALTO. MD 21133</b>		31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature <b>[Signature]</b>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



CJ  
William D.  
Brown

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22252

ITEM: #20-C PER F.H. G773 7-19-99 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>William R. Brown</i>				2. Date of Death Month Day Year <i>July 12 1999</i>				3. Time of Death <i>12:01 PM.</i>			
	4a. Facility Name (If not institution, give street and number) <i>401 East 25th Street #3M</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>W/P</i>			
Funeral Director	5. Social Security Number <i>220-36-7013</i>		6. Sex <i>18 M 20 F</i>		7. Age (In yrs. last birthday) <i>57</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>JAN 10, 1942</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>W/P</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <i>1 Yes 2 No</i>			
	10e. Street and Number <i>401 E. 25th Street #413</i>				10f. Zip Code <i>21218</i>		10g. Citizen of What Country? <i>USA</i>					
	11. Marital Status <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>		12. Was Decedent Ever in U.S. Armed Forces? <i>1 Yes 2 No</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 Yes 2 No Specify:</i>			14. Race - American Indian, Black, White, etc. <i>Specify: black</i>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i> <i>1 year</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>TEACHER</i>				16b. Kind of Business/Industry <i>Baltimore City PUBLIC SCHOOLS</i>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>George R. Brown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Henrie McCarry</i>							
	19a. Informant's Name/Relationship (Type, Print) <i>Mary E. Brown wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8326 E. Baltimore Street Baltimore, Md 21224</i>							
	20a. Method of Disposition <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>KING MEMORIAL PARK</i>		20c. Location - City or Town, State <i>WOODLAWN, MARYLAND</i>		20d. Date <i>7-17-99</i>					
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>CHATHAM - Harris &amp; A. 5240 KESTERSON ROAD Baltimore, Md 21208</i>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. ANTIPOSSUMOTIC COMBINATION DISEASE</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <i>1 Yes 2 No 3 Probably 4 Unknown</i>	
	25. Was case referred to medical examiner? <i>1 Yes 2 No</i>										24e. Was an autopsy performed? <i>1 Yes 2 No</i>	
	26. Place of Death (Check only one) Hospital: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> Other: <i>4 Nursing Home 5 Residence 8 Other (Specify)</i>										24b. Were autopsy findings available prior to completion of cause of death? <i>1 Yes 2 No</i>	
State Registrar	27. Manner of Death <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</i>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <i>1 Yes 2 No</i>		28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <i>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> <i>2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</i>											
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>O.C.M.E.</i>				29d. Date signed (Month, Day, Year) <i>July 13, 1999</i>			
State Registrar	30. Name and address of person who completed cause of death (item 23a) (Type, Print) <i>Waldemar D. Kozak 111 Penn Street, Baltimore, Maryland 21201</i>											
	31. Date filed (Month, Day, Year) <i>JUL 15 1999</i>		32. Registrar's Signature <i>[Signature]</i>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22253

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grace Brown

2. Date of Death

Month Day Year  
July 12 1999

3. Time of Death

8:20 PM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Cromwell

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

5. Social Security Number

235-36-5330

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Nov. 10 1923

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3833 E. Joppa Rd

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

17. Father's Name (First, Middle, Last)

Harry Shock

18. Mother's Name (First, Middle, Maiden Surname)

Emma Tompkins

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Dennis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3833 E. Joppa Rd. Perry Hall, Md 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Ceme.

Date

July 16 1999

20c. Location - City or Town, State

Garrison, Md

21. Signature of Funeral Service Licensee

Keita S. Wells

22. Name and Address of Facility

Evans Funeral Chapel  
8800 Harford Rd Baltimore, Md 21234

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CERVICAL CANCER.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. B. B. B. B.

29c. License number

D52228

29d. Date signed (Month, Day, Year)

7/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIPULKUMAR BHALODIYA, 3007 E. NORTHERN PKWY, BALTIMORE, MD 21214

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

B. B. B. B.

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22254

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel

Brown

2. Date of Death

Month

Day

Year

July 13, 1999

3. Time of Death

8:41 Am

4a. Facility Name (If not institution, give street and number)

THE Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore, City

4c. County of Death

Funeral  
Director

5. Social Security Number

219-52-6315

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
8 50 49

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

306 S. Mason Ct.

10f. Zip Code

21231

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

High

College (1-4 or 5+)

College

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Janitor

16b. Kind of Business/Industry

Maid &amp; Janitor Service

17. Father's Name (First, Middle, Last)

Henry Brown

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Dowds

19a. Informant's Name/Relationship (Type, Print)

Patrice Brown - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 W. Hoffman St 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Cemetery

Date

7/17/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

Jeff Miller Funeral Home  
1634 N. Broadway

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. anoxic brain injury

Due to (or as a consequence of):

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ventricular fibrillation

Due to (or as a consequence of):

10 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension  
alcohol abuse

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lisa Sanders MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lisa Sanders, Johns Hopkins Hospital

Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Amended Item#23apt1 perPhy G773 7/15/99 EW

1. Decedent's Name (First, Middle, Last) <b>James Brown</b>		2. Date of Death Month <b>July</b> Day <b>2</b> Year <b>1999</b>		3. Time of Death <b>9:10 AM</b>			
4a. Facility Name (If not institution, give street and number) <b>Church Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
5. Social Security Number <b>218-14-7144</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 25, 1923</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>603 Tee Jay Lane</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9 Years</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Carpentry</b>			
17. Father's Name (First, Middle, Last) <b>Joseph Brown</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Beatty</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Clara M. Brown / Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>603 Tee Jay Lane Dundalk, Maryland 21222</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem. 7/5/1999</b>		Date <b>7/5/1999</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licenses 		22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Respiratory Distress Syndrome</b> Due to (or as a consequence of): <b>b. Aspiration PNEUMONIA</b> Due to (or as a consequence of): <b>c. Upper GI Bleeding</b> Due to (or as a consequence of): <b>d.</b>						Approximate Interval Between Onset and Death <b>3 days</b> <b>4 days</b> <b>1 week</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis Shock, Anemia; Non Q MI, Pulmonary Edema, Acute Renal Failure, COPD,</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>7/2/1999</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>046120</b>		29d. Date signed (Month, Day, Year) <b>July 2, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>F DeLeon 98 W Broadway Baltimore, MD 21231</b>							
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22256

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Buchholz				2. Date of Death Month Day Year July 14, 1999		3. Time of Death 6:33 AM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-16-2429		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) May 22, 1924	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 4602 Ballygar Road		10f. Zip Code 21236	
	10g. Citizen of What Country? United States of America				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) n/a	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipe Fitter				16b. Kind of Business/Industry Bethlehem Steel			
	17. Father's Name (First, Middle, Last) William Buchholz, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Margaret Ahlers			
	19a. Informant's Name/Relationship (Type, Print) (Wife) Mrs. Rose Marie(nee Messina)Buchholz				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4602 Ballygar Road Baltimore, Maryland 21236			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery			
	20c. Location - City or Town, State Baltimore, Maryland				20d. Date 7/17/1999			
	21. Signature of Funeral Service Licensee Mary E. Jain				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart Failure Due to (or as a consequence of): Crown Artery Dx Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COPD				Approximate Interval Between Onset and Death hours yrs			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Mark Lamos MD				
29c. License number D 34521				29d. Date signed (Month, Day, Year) 7-15-99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mark Lamos 9 Schilling Road Hunt Valley, Maryland 21030				31. Date filed (Month, Day, Year) JUL 15 1999				
32. Registrar's Signature B. Sparks				State Registrar				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22257

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Laverne Boone</b>				2. Date of Death Month <b>July</b> Day <b>11</b> Year <b>1999</b>		3. Time of Death <b>1:10 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mercy Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>212-46-4514</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>54</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05 16 45</b>	9. Birthplace (State or Foreign Country) <b>M.D.</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore Co.</b>		10c. City, Town or Location <b>Catonsville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>324 Holly Manor Road</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+) <b>na</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer Operator</b>		16b. Kind of Business/Industry <b>Balto Gas &amp; Electric</b>		
17. Father's Name (First, Middle, Last) <b>Edward Johnson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Brown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Wilbert Boone-Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>324 Holly Manor Road, Catonsville Md 21228</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet 7/15/99 Owings Mills, Md</b>						
21. Signature of Funeral Service Licensee <b>Gladys W. Jones</b>				22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Hepatic failure</b> Due to (or as a consequence of): <b>Acute leukemia</b>  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Weeks</b> <b>Weeks</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure, respiratory failure, sepsis, anemia, thrombocytopenia</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier <b>Wm Todd W</b>				29c. License number <b>D37790</b>		29d. Date signed (Month, Day, Year) <b>July 11, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Norris W Todd 301 St Paul Place Baltimore MD 21202</b>								
31. Date (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature <b>G. Sparks</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1942

1942

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22258

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Alice Mary Anna Conrad</b>				2. Date of Death Month <b>July</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>10:00 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>1906 Oxley Road</b>				4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>220-22-5176</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 18, 1927</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1906 Oxley Road</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 Years</b> College (14 or 5+) <b>Housewife</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Thomas Ashley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Sparwasser</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Son</b> <b>Vernon C. Bewig, Jr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1906 Oxley Road Dundalk, Maryland 21222</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		Date <b>7/16/1999</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b> <b>7922 Wise Ave. Dundalk, Maryland 21222</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number <b>D26835</b>		29d. Date signed (Month, Day, Year) <b>7/17/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul A. Valle MD 1576 Merritt Blvd 21222</b>							
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, E

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22259

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Pauline Citrenbaum

2. Date of Death

Month Day Year  
July 11, 1999

3. Time of Death

2:38 pm

4a. Facility Name (If not institution, give street and number)

Sina Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-05-2891

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 14, 1917

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3031 FALLSTAFF ROAD #208

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JACOB

STEINBERG

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

SONDELL

19a. Informant's Name/Relationship (Type, Print)

IRVIN CITRENBUM - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3031 FALLSTAFF ROAD #208 - BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ANSHE EMUNAH AITZ CHAIM

Date

7/12/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES000

29d. Date signed (Month, Day, Year)

July 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marcus D. Smith 2401 Belvedere, Baltimore, MD 21215

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

Denise B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

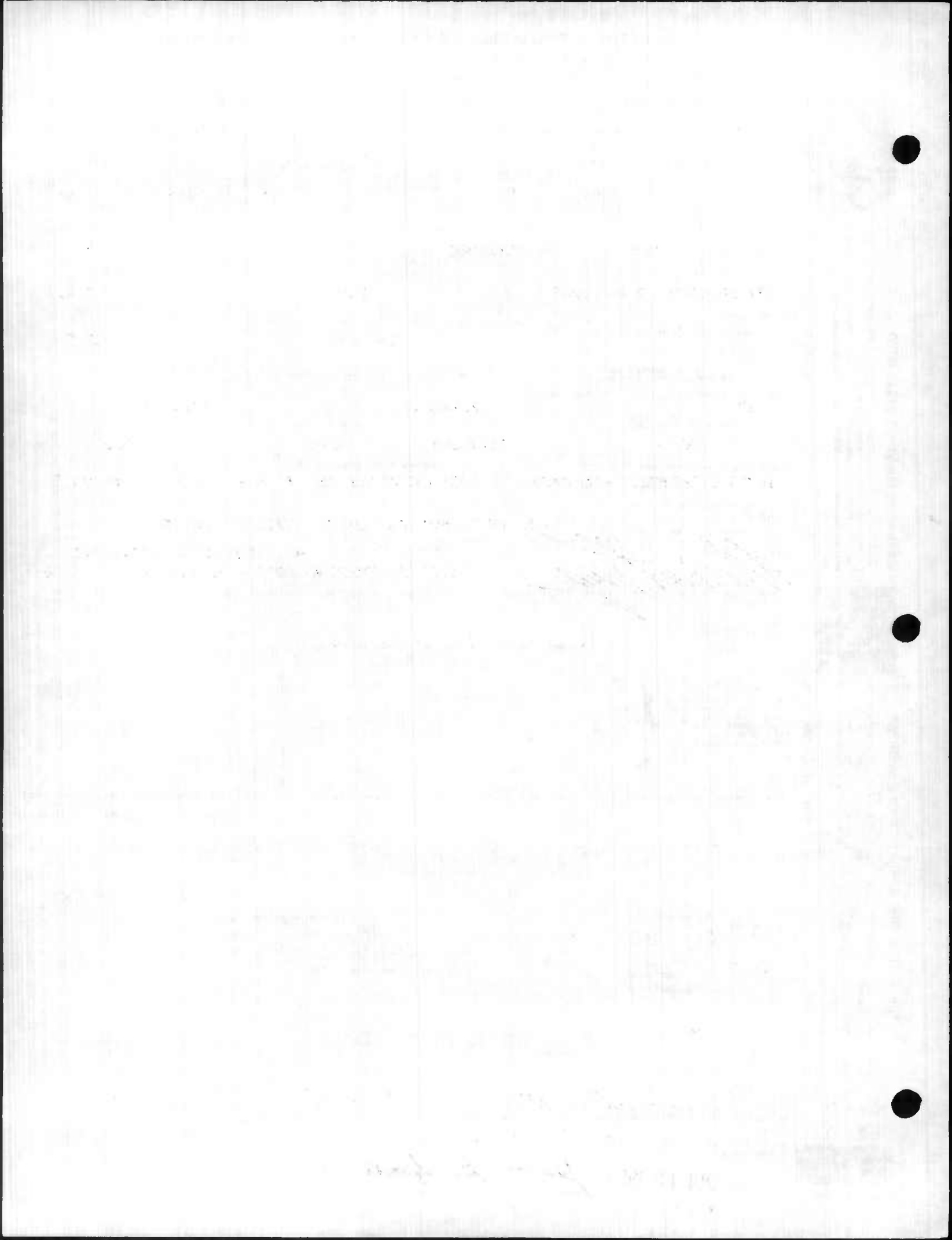
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22260

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Crosby

2. Date of Death

Month

Day

Year

3. Time of Death

9:45 Am

4a. Facility Name (If not institution, give street and number)

Genesis Elderhome - Cromwell

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-07-9267

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

4-3-1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21 Treeway Court

10f. Zip Code

21286

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Manager

16b. Kind of Business/Industry

Kelly Buick

17. Father's Name (First, Middle, Last)

William F. Crosby

18. Mother's Name (First, Middle, Maiden Summe)

Adeline Turner

19a. Informant's Name/Relationship (Type, Print)

Mrs Jean A. Crosby (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Treeway Court, Towson, Md. 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

7-16-99

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Wallace S. Brooks, Jr.

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Road, Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. DEMENTIA

Due to (or as a consequence of):

c. FAILURE TO THRIVE

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D52228

29d. Date signed (Month, Day, Year)

7/14/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

VIBULKUMAR BHARDIYA, 3007 E. NORTHERN PKWY, BALTIMORE MD 21214

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

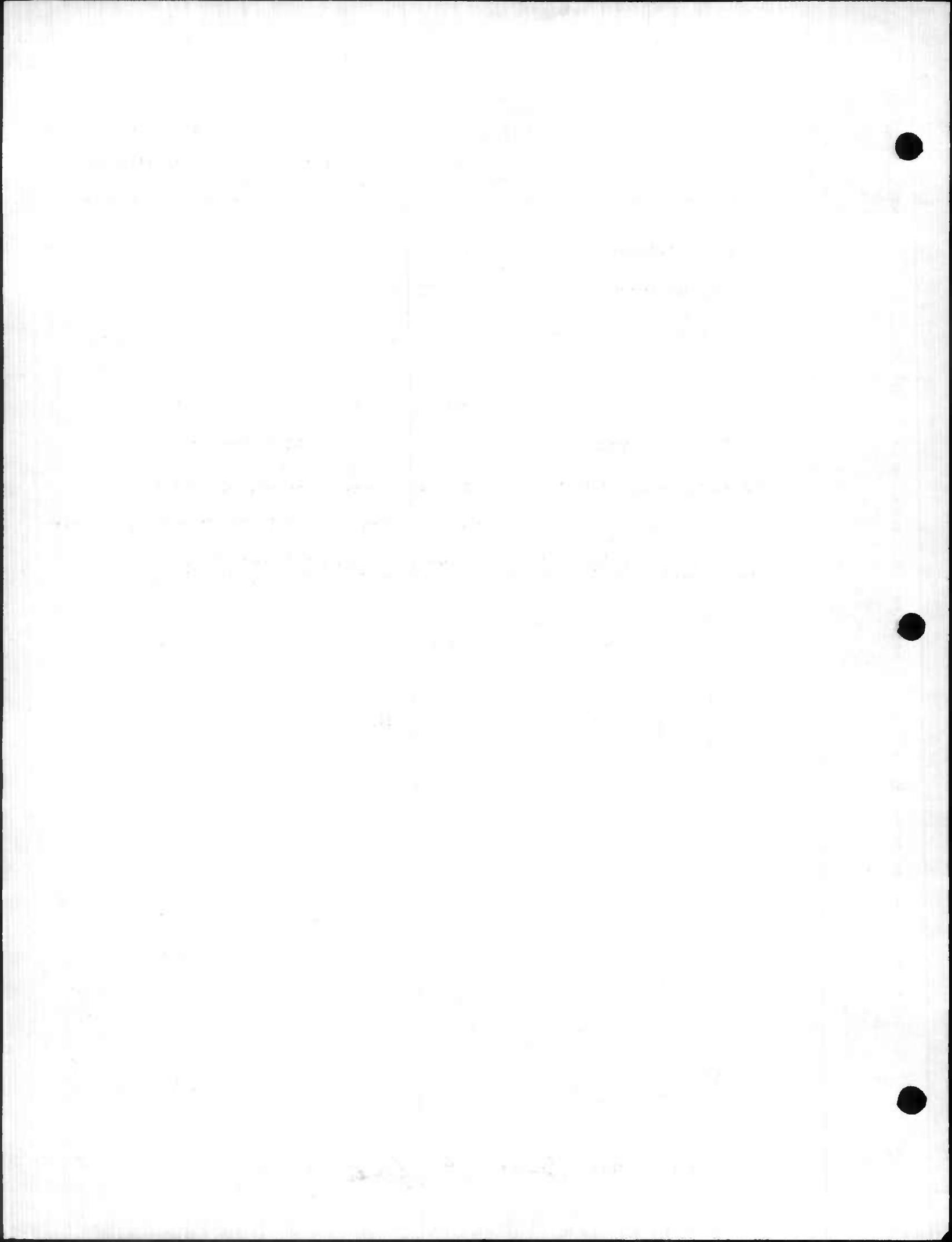
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22261

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Suzanne Willson Davis

2. Date of Death

Month Day Year  
July 14 1999

3. Time of Death

5:57AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

255-48-2507

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 02 1927

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

191 Gittings Ave.

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Systems Analyst

16b. Kind of Business/Industry

DP Associates

17. Father's Name (First, Middle, Last)

William Harry Willson

18. Mother's Name (First, Middle, Maiden Surname)

Suzanne Van Arsdale

19a. Informant's Name/Relationship (Type, Print)

Mr. Ralph E. Davis/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

191 Gittings Ave, Baltimore, MD. 21212

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Co.

Date

7-15-99

20c. Location - City or Town, State

Towson, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd, Towson, MD. 21204

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Breast cancer

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☒ Other (Specify)

Hospice

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide  
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Anthony Riley, MD. GBMC 6701 N. Charles St. Baltimore, MD. 21204

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State

10. 11. 1964

11. 11. 1964

12. 11. 1964

13. 11. 1964

14. 11. 1964

15. 11. 1964

16. 11. 1964

17. 11. 1964

18. 11. 1964

19. 11. 1964

20. 11. 1964

21. 11. 1964

22. 11. 1964

23. 11. 1964

24. 11. 1964

25. 11. 1964

26. 11. 1964

27. 11. 1964

28. 11. 1964

29. 11. 1964

30. 11. 1964

31. 11. 1964

32. 11. 1964

33. 11. 1964

34. 11. 1964

35. 11. 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22262  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Adeline Pauline DeLabio

2. Date of Death

Month Day Year  
July 11, 1999

3. Time of Death

2:00pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2014 Griffis Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-18-4978

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 27, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2014 Griffis Avenue

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Charles Paul Richards

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Hubert

19a. Informant's Name/Relationship (Type, Print)

Lisa M. Stagmer/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

522 Old Westminster Pike Westminster, Maryland 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Cemetery

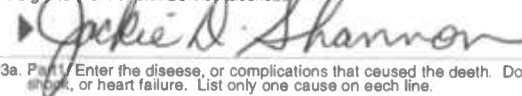
Date

7/14/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue Baltimore, Maryland 21229

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic Cardiovascular disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Hypertension*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

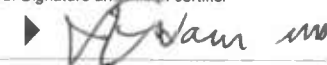
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier



29c. License number

D20040

29d. Date signed (Month, Day, Year)

7/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Evans MD, 700 Washington Blvd, Baltimore MD, 21230

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

A710

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

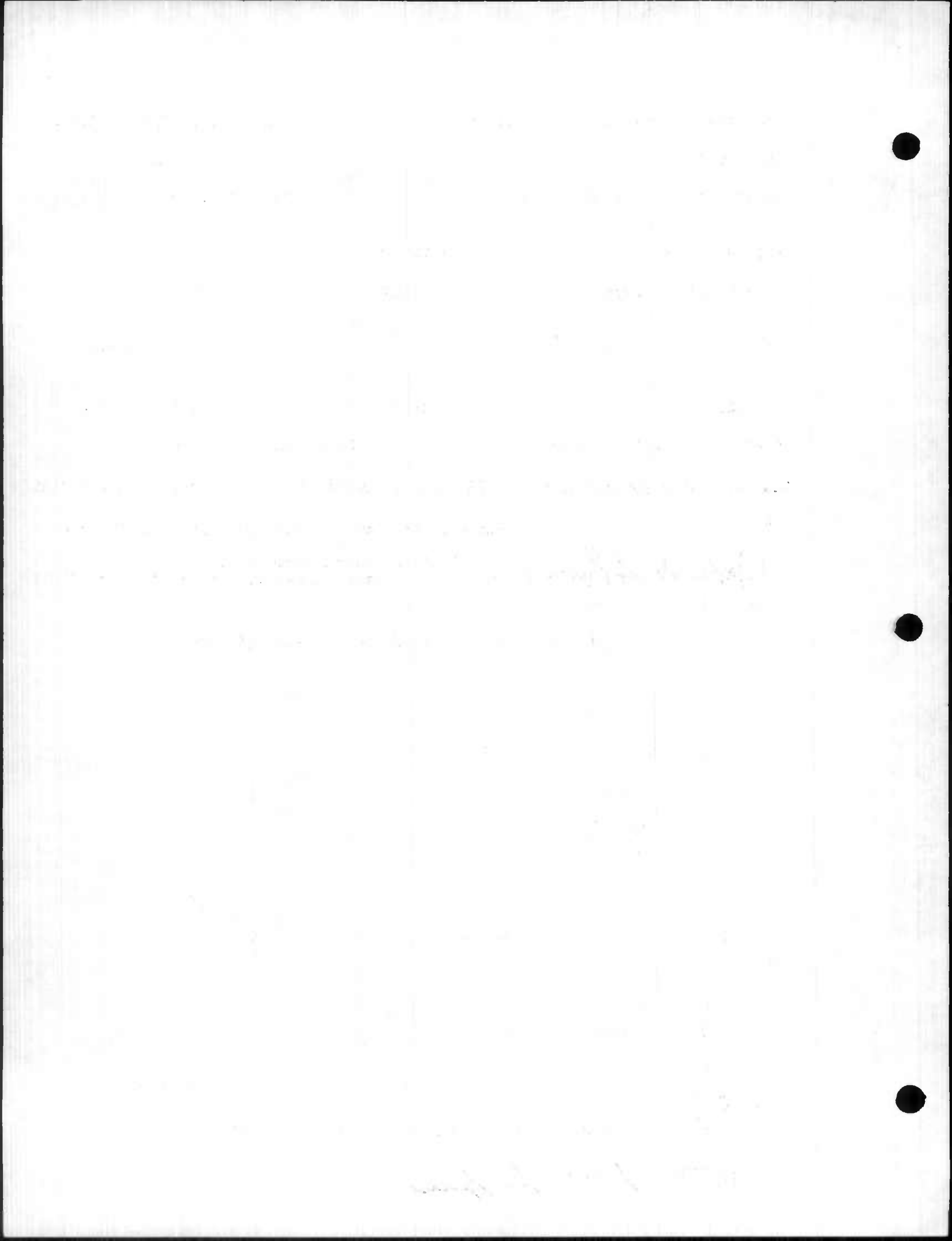
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



WRC  
99-4061-033  
JAMMIE L.  
DANNERMAN AMEND: ITEMS: #23 PART I, 27 PER MEO G773 7/29

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22263

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jaime Leigh Dannemann				2. Date of Death Month Day Year JULY 12, 1999		3. Time of Death 1:10 PM.								
	4a. Facility Name (If not institution, give street and number) 8125 48th. AVE. #614				4b. City, Town, or Location of Death COLLEGE PARK		4c. County of Death Prince Georges								
Funeral Director	5. Social Security Number 048-82-9184		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 22 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 21, 1977		9. Birthplace (State or Foreign Country) Massachusetts						
	Usual Residence of Decedent														
10a. State CT		10b. County New Haven		10c. City, Town or Location Madison				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 230 Horsepond Rd.				10f. Zip Code 06443		10g. Citizen of What Country? USA									
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student			16b. Kind of Business/Industry University of Md.								
17. Father's Name (First, Middle, Last) Eric Dannemann					18. Mother's Name (First, Middle, Maiden Surname) Judith Little										
19a. Informant's Name/Relationship (Type, Print) Judith Little - mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Horsepond Rd., Madison, CT. 06443										
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Riverview Crematory			Data 7/17/99		20c. Location - City or Town, State Old Saybrook, CT.							
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., ElkrIDGE, Md. 21075										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) ACUTE ASTHMA Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 13, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE DANNERMAN 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) JUL 14 1999			32. Registrar's Signature 												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22264

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank Anthony Eff, Sr.				2. Date of Death Month Day Year July 13, 1999		3. Time of Death 12:30 p.m.		
	4e. Facility Name (If not Institution, give street and number) 3008 Wylie Ave.				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 215-12-0435	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 7, 1914		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10e. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 3008 Wylie Avenue			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7yrs		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed		16b. Kind of Business/Industry Contractor		
	17. Father's Name (First, Middle, Last) Otto Eff				18. Mother's Name (First, Middle, Maiden Surname) Margaret Waldhauser				
	19e. Informant's Name/Relationship (Type, Print) Joseph A. Eff / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 East Main Blvd. Timonium, Maryland 21093				
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 7/16/99		20c. Location - City or Town, State Towson, Maryland		
	21. Signature of Funeral Service Licensee Earl L. Parag				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204				
	23a. Pertinent. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. <u>Hypertension</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death years								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Attending Physician				29c. License number D16965		29d. Date signed (Month, Day, Year) 7/14/99			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Barbara Cochran, M.D. 846 W. 36th Street Baltimore, Maryland									
31. Date filed (Month, Day, Year) JUL 15 1999				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

My dear Sir,  
I have the pleasure to inform you that  
the same has been forwarded to you  
by the same conveyance as the  
other documents which you were  
good enough to send me.  
I am, Sir, very respectfully,  
Your obedient servant,  
J. W. F. [Signature]

Yours faithfully,  
J. W. F. [Signature]

Yours faithfully,  
J. W. F. [Signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22265

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ben Gill

2. Date of Death

July 13, 1999

3. Time of Death

5026 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

218-30-0880

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 20, 1910

9. Birthplace (State or Foreign Country)

TN

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rainbow Hall; Room 227  
10729 Park Heights Avenue

10f. Zip Code

21117

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Land Scaper

16b. Kind of Business/Industry

Private Estates

17. Father's Name (First, Middle, Last)

Charles Clay Gill

18. Mother's Name (First, Middle, Maiden Surname)

Allene Carpenter

19a. Informant's Name/Relationship (Type, Print)

William C. Gill - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

902 Conner Road; West Chester, Pennsylvania 19380

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lake View Mem. Park

Date

7/16/99

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.  
8728 Liberty Road; Randallstown, Maryland 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. A white myocardial infarction  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H43974

29d. Date signed (Month, Day, Year)

July 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice Hsieh Northwest Hospital Randallstown, Md

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22266

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CAROLYN MARIE GARNER				2. Date of Death Month Day Year JULY 13 1999		3. Time of Death 7:10AM	
	4a. Facility Name (If not institution, give street and number) 409 PATUXENT COURT				4b. City, Town, or Location of Death LA PLATA		4c. County of Death CHARLES	
Funeral Director	5. Social Security Number 212-92-8286		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 29 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 14, 1970	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Charles		10c. City, Town or Location LaPlata	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 409 Patuxent Road		10f. Zip Code 20646		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Gabriel Lee Garner Jr.				18. Mother's Name (First, Middle, Maiden Surname) Carol Elizabeth Crigger			
	19a. Informant's Name/Relationship (Type, Print) Carol Garner/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Patuxent Road LaPlata, MD 20646			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven mem. Pk.		20c. Date July 15, 1999		20d. Location - City or Town, State Glen Burnie, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. BRAIN CANCER Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D28352		29d. Date signed (Month, Day, Year) JULY 13, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRISHAN MATHUR, MD., P.O. BOX 1703, LA PLATA, MD 20646								
31. Date filed (Month, Day, Year) JUL 15 1999				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner


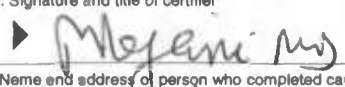
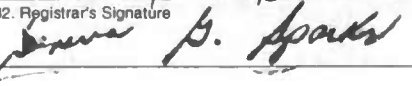


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22267

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NORMAN</b>		2. Date of Death Month Day Year <b>JULY 11 1999</b>		3. Time of Death <b>7:12 PM</b>																								
	4a. Facility Name (If not institution, give street and number) <b>LEVINDALE HEBREW HOME</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>																								
Funeral Director	5. Social Security Number <b>220-05-0580</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.																								
	8. Date of Birth (Month, Day, Year) <b>NOV. 11, 1919</b>		9. Birthplace (State or Foreign Country) <b>NY</b>																										
Usual Residence of Decedent																													
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>																									
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																													
10e. Street and Number <b>3410 ROCKDALE COURT</b>			10f. Zip Code <b>21244</b>		10g. Citizen of What Country? <b>U.S.A.</b>																								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:																									
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>																													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESMAN</b>		16b. Kind of Business/Industry <b>GARMENT</b>																									
17. Father's Name (First, Middle, Last) <b>CHARLES</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA SHUGAMS</b>																										
19a. Informant's Name/Relationship (Type, Print) <b>MICHAEL GLASS / SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3410 ROCKDALE COURT - BALTIMORE, MD 21244</b>																										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON CHIZUK AMUNO</b>		Date <b>7/14/99</b>	20c. Location - City or Town, State <b>BALTIMORE, MD</b>																								
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>																											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																													
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><i>Aspiration pneumonia</i></td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td><i>7/week</i></td> </tr> <tr> <td>b.</td> <td><i>Cerebral vascular accident</i></td> <td><i>7/years</i></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td><i>7/years</i></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td><i>per kin sonus m</i></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">d.</td> <td></td> <td></td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)	a.	<i>Aspiration pneumonia</i>	Approximate Interval Between Onset and Death	Due to (or as a consequence of):		<i>7/week</i>	b.	<i>Cerebral vascular accident</i>	<i>7/years</i>	Due to (or as a consequence of):		<i>7/years</i>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	<i>per kin sonus m</i>		Due to (or as a consequence of):			d.			
Immediate Cause (Final disease or condition resulting in death)	a.	<i>Aspiration pneumonia</i>	Approximate Interval Between Onset and Death																										
	Due to (or as a consequence of):		<i>7/week</i>																										
	b.	<i>Cerebral vascular accident</i>	<i>7/years</i>																										
	Due to (or as a consequence of):		<i>7/years</i>																										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	<i>per kin sonus m</i>																											
	Due to (or as a consequence of):																												
d.																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																													
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																													
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>																									
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																													
29b. Signature and title of certifier 		29c. License number <b>D44817</b>		29d. Date signed (Month, Day, Year) <b>JULY 12 1999</b>																									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sumit Mehani 2434 W. Schuette Ave, Baltimore, Md 21215</b>																													
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature 																											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

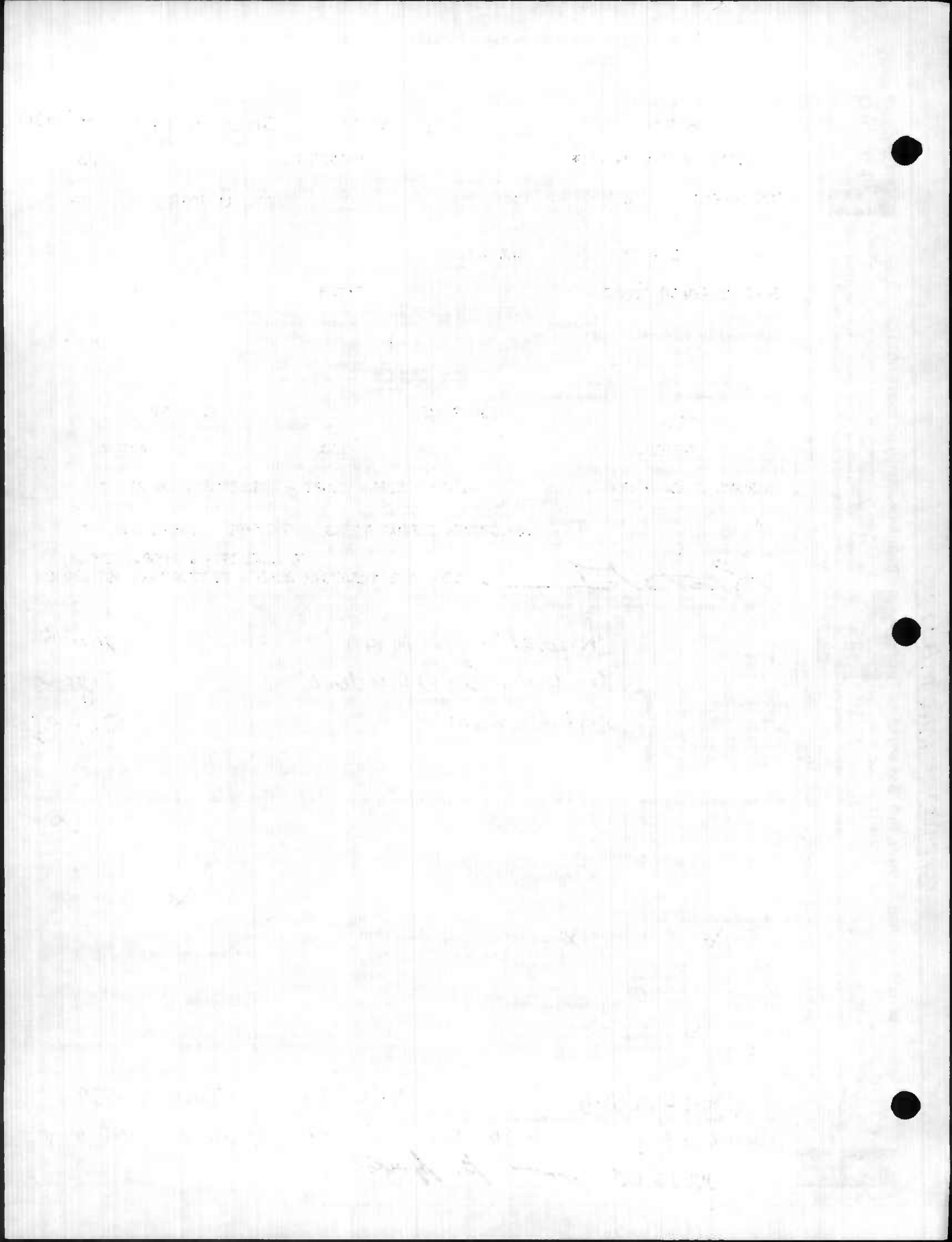
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar







ADH  
OUNG YIM GEORGE  
99-4065-025

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22268

AMEND ITEM: #23 PART I, PER MEO G774 8-17-99 WR.

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Yong Yim George

2. Date of Death

Month JULY Day 12, Year 1999

3. Time of Death

1900 PM

4a. Facility Name (If not institution, give street and number)

988 HOSPITALITY WAY

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

431-31-7313

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEP 21, 1952

9. Birthplace (State or Foreign Country)

Korea

Usual Residence of Decedent

10a. State

MI

10b. County

McComb

10c. City, Town or Location

Sterling Heights

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4554 Hatherly Place

10f. Zip Code

48310

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: Korean

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Customer Service

16b. Kind of Business/Industry

Cleaners

17. Father's Name (First, Middle, Last)

(Unavailable)

18. Mother's Name (First, Middle, Maiden Surname)

(Unavailable)

19a. Informant's Name/Relationship (Type, Print)

Ernest George - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4554 Hatherly Place, Sterling Heights, MI 48310

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Evergreen Cemetery

Date

7/17/99

20c. Location - City or Town, State

Louisville, Kentucky

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.  
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

SUBARACHNOID HEMORRHAGE DUE TO RUPTURED ANEURYSM OF LEFT  
INTERNAL CAROTID ARTERY

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy  
performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. HAYS

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 15 1999

3. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-342-1234.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

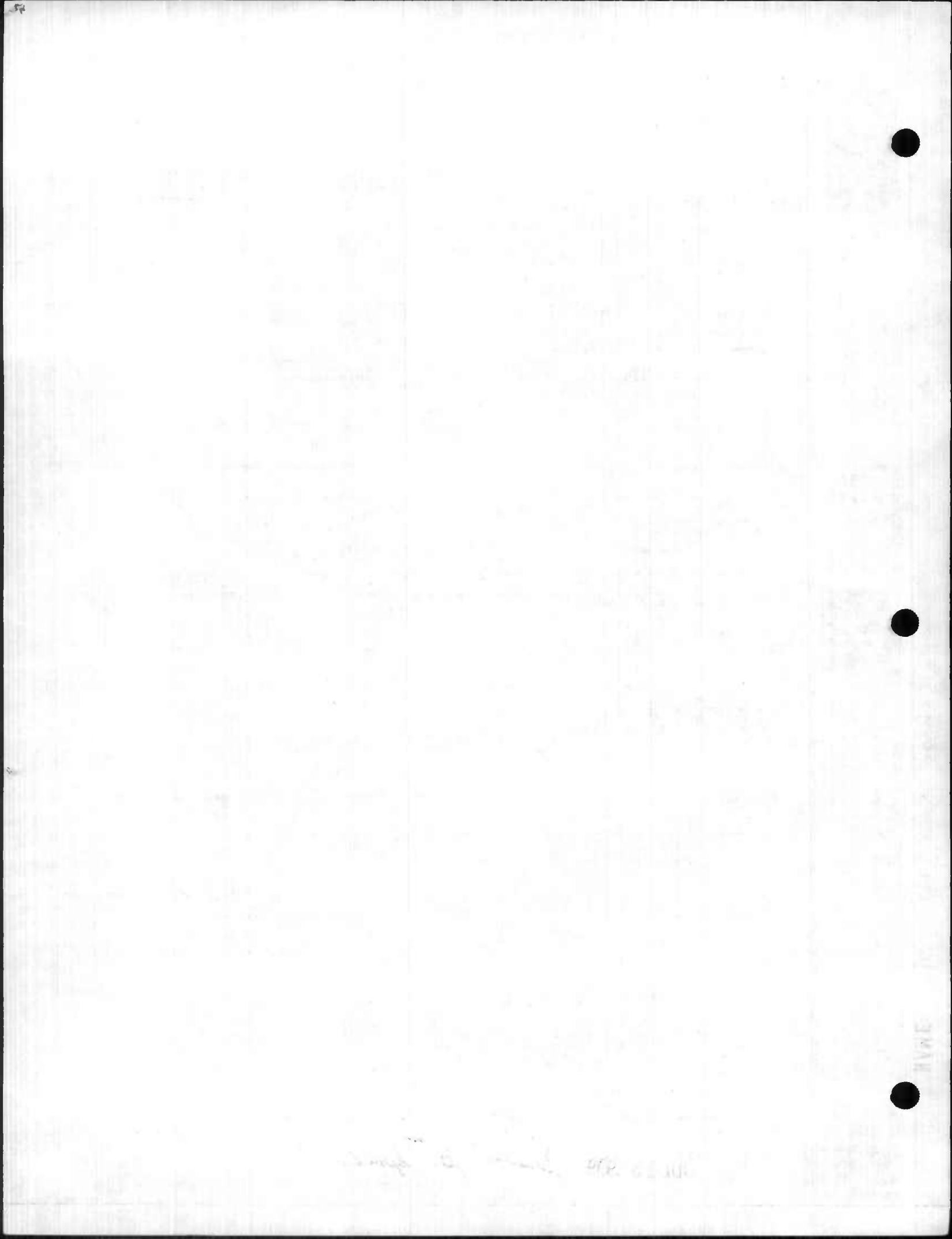
State of Maryland / Department of Health and Mental Hygiene 99 22269

Amended Item#8 perFH G773 7/15/99 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys Virginia Homan				2. Date of Death Month Day Year July 13 1999		3. Time of Death 13:40 PM	
	4a. Facility Name (If not institution, give street and number) St Agnes health care				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 214-20-6458		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 16, 1905	9. Birthplace (State or Foreign Country) VA
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 914 Old Maiden Choice Lane				10f. Zip Code 21229		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Food Service		
17. Father's Name (First, Middle, Last) Ellis R. Gwin				18. Mother's Name (First, Middle, Maiden Surname) Marion L. Mickelboro				
19a. Informant's Name/Relationship (Type, Print) Marion Hedrick				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Old Maiden Choice Lane, Baltimore, MD 21229				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Park		Date 7-17-99		20c. Location - City or Town, State Timonium, Maryland		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Rd., Arbutus, MD 21227				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Urinary tract infection Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. CHF  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Days Days Years 12 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease. HTN								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier M.D.				29c. License number P12595		29d. Date signed (Month, Day, Year) July 13, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mustapha Mallah M.D. 900 Caton Avenue Baltimore, MD 21229.								
31. Date filed (Month, Day, Year) JUL 15 1999		32. Registrar's Signature B. Sparks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22270

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL V. HOLOMAN

2. Date of Death  
Month Day Year

JULY 14 1999

3. Time of Death

1020 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Eastpoint Rehab &amp; Nursing Center

4b. City, Town, or Location of Death

Eastpoint

4c. County of Death

Baltimore

5. Social Security Number

217-20-8003

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 23 1925

9. Birthplace (State or Foreign County)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Eastpoint

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1046 Old North Point Road

10f. Zip Code

21222

10g. Citizen of What Country?

U.S. of America

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8College (1-4 or 5+)  
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Martin

Holoman Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Mary

Unknown

19a. Informant's Name/Relationship (Type, Print)

Mary Ann Fila (Nrice)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1013 Big Baer Dr. Glen Burnie, Md. 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Mary

Date

July 16

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

W. Dabrowski-Choynacki F.H.'s P.A.  
1005 Dundalk Ave. Balto., Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

b. Dysphagia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Breast Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

045757

29d. Date signed (Month, Day, Year)

JULY 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW MCNABNEY 4440 EXETER AVE DART MD 21224

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22271

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE IDA JONES

2. Date of Death

Month  
JULYDay  
8Year  
1999

3. Time of Death

8:10PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

BALTIMORE COUNTY

4c. County of Death

BALTIMORE

5. Social Security Number

217-22-2946

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year

June 7, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4223 Chapel Rd.

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th gradeCollege (1-4 or 5+)  
N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)  
Homemaker

16b. Kind of Business/Industry

Homemaking-Own Home

17. Father's Name (First, Middle, Last)

Lawrence H. Offutt

18. Mother's Name (First, Middle, Maiden Surname)

Mabel U. Brown

19a. Informant's Name/Relationship (Type, Print)

Mr. Charles R. Cline

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12032 Jerusalem Rd. Kingsville, Md. 21087

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

7-10-99

20c. Location - City or Town, State

Belair, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

E. F. Lassahn Funeral Home

11750 Belair Rd. Kingsville, Md. 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify)

HOSPICE

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

State  
Registrar

ALICE JONES July 8, 1999 8:10 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 22272

AMENDED ITEMS #10c #20b PER FH G773 7/15/99 AH

Physician  
(Medical  
Examiner)Funeral  
Director

1. Decedent's Name (First, Middle, Last)

JANE

JOHNSON

2. Date of Death

Month Day Year

JULY 11 1999

3. Time of Death

13:32 PM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

216-28-6011

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02 25 30

9. Birthplace (State or Foreign Country)

V.A.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2121 Windsor Gardens Lane #529C

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

na

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housing Authority

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Robert Simms

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Sommerville

19a. Informant's Name/Relationship (Type, Print)

Wanda Johnson-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5011 Andalusia Trail, Arlington, Tx 76017

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

7/14/99

20c. Location - City or Town, State

7/13/99 Baltimore, Md

21. Signature of Funeral Service Licensee

Shannon Stokes

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

a. PERITONEAL BLEED (INTRA-ABDOMINAL)

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

c. HEPATOCELLULAR CARCINOMA

Due to (or as a consequence of):

d.

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEPATITIS C

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bowers

RESIDENT PHYSICIAN

29c. License number

RES-001

29d. Date signed (Month, Day, Year)

JULY 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANELLE R. BOWERS, MD

SINAI HOSPITAL

2101 WEST BELVEDERE AVENUE

BALTIMORE, MD 21215

31. Date filed (Month, Day, Year)

32. Registrar's Signature

▶

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
(Medical  
Examiner)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#5 perFH G773 7/15/99 EW

Certificate of Death

Reg. No. 99 22273

KENNEY, LOUISE  
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>LOUISE W. KENNEY</b>		2. Date of Death Month Day Year <b>July 07, 1999</b>		3. Time of Death <b>11:25 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>OAKCREST VILLAGE CARE CENTER</b>			4b. City, Town, or Location of Death <b>BALTIMORE COUNTY</b>		4c. County of Death <b>BALTIMORE</b>
5. Social Security Number <b>213-32-1010</b> <b>820-05-7591</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 27, 1914</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Baltimore County</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>11134 Old Carriage Rd.</b>		10f. Zip Code <b>21057</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+) <b>N/A</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Homemaking-Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Vernon Montgomery Weaver</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Neserke</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Bernice K. Morgan</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11134 Old Carriage Rd. Glen Arm, Maryland 21057</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Lassahn Funeral Home</b> <b>7401 Belair Rd. Baltimore, Md. 21236</b>			

Division of Vital Records, P.O. Box 68760, 2

To Be Completed by Physician/Medical Examiner

23a. Find, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
a. <b>Congestive Heart failure</b>		<b>5 yrs</b>	
b. <b>Ischemic Heart Disease</b>		<b>10 yrs</b>	
c. <b>Type II Diabetes mellitus</b>		<b>10 yrs</b>	
d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Insufficiency</b>			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <i>William Russell</i>		29c. License number <b>D30182</b>	
29d. Date signed (Month, Day, Year) <b>July 8, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Russell MD 8800 WALTER BLVD BALTIMORE MD 21234</b>	
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature <i>[Signature]</i>	

Page 11-113

Handwritten signature or text at the bottom of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 22274

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Druey F. Kidd</b>				2. Date of Death Month <b>July</b> Day <b>8th</b> Year <b>1999</b>		3. Time of Death <b>5:00 pm</b>							
	4a. Facility Name (If not institution, give street and number) <b>Levindale Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death							
Funeral Director	5. Social Security Number <b>218-16-0289</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>09 25 10</b>							
	9. Birthplace (State or Foreign Country) <b>M.D.</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>							
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2917 Woodland Ave</b>		10f. Zip Code <b>21215</b>								
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:								
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>NA</b> College (1-4or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Unknown</b>								
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>										
19a. Informant's Name/Relationship (Type, Print) <b>Freda Baugh-Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2917 Woodland Ave, Baltimore Md 21215</b>										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Zion Cemetery 7/14/99 Baltimore Md</b>										
21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>acute cardiac arrest</b></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>atherosclerotic cardiac disease</b></td> </tr> <tr> <td>c. <b>ventilation dependent</b></td> </tr> <tr> <td>d. <b>chronic obstructive pulmonary disease</b></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>acute cardiac arrest</b>	Approximate Interval Between Onset and Death	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>atherosclerotic cardiac disease</b>	c. <b>ventilation dependent</b>	d. <b>chronic obstructive pulmonary disease</b>
Immediate Cause (Final disease or condition resulting in death)	a. <b>acute cardiac arrest</b>	Approximate Interval Between Onset and Death												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>atherosclerotic cardiac disease</b>													
	c. <b>ventilation dependent</b>													
	d. <b>chronic obstructive pulmonary disease</b>													
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>dementia hypothyroidism</b> <b>decreased cardiac output</b> <b>1570 gastrointestinal bleed cardiac stenosis</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D-44907</b>		29d. Date signed (Month, Day, Year) <b>July 8th 1999</b>								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>2434 W. Silverdale Ave Baltimore, MD 21215</b>														
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>				32. Registrar's Signature <b>[Signature]</b>										

To Be Completed by Funeral Director

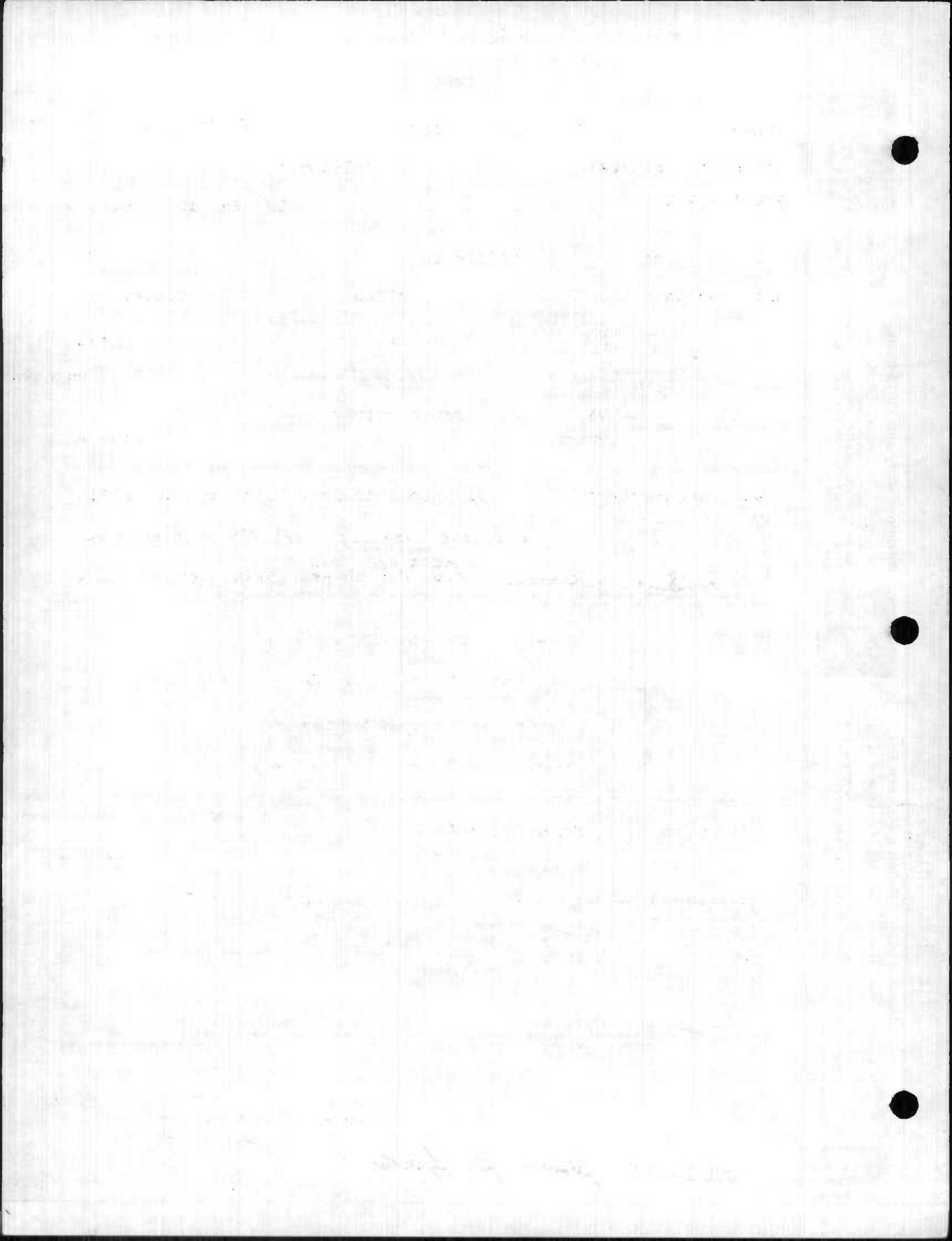
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22275

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Morris Thomas Leach</b>				2. Date of Death Month <b>6</b> Day <b>30</b> Year <b>99</b>		3. Time of Death <b>8:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>15 E. Main Street</b>				4b. City, Town, or Location of Death <b>Hancock</b>		4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>219-44-4366</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb 8, 1948</b>	9. Birthplace (State or Foreign Country) <b>VA</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hancock</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>15 E. Main Street</b>				10f. Zip Code <b>21750</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>1968-1970</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Labor</b>		16b. Kind of Business/Industry <b>Brake Mfg.</b>		
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lorriane Leach</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Wilma L. Harvey Leach/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 E. Main Street Hancock, MD 21750</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Tonoloway Cemetery</b>		20c. Location - City or Town, State <b>7/2/99 Needmore, PA</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750</b>				
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. Carcinoma unknown primary</b>								<b>6 months</b>
Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Michael J. McCormack MD</b>				29c. License number <b>041667</b>		29d. Date signed (Month, Day, Year) <b>7.2.99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael J. McCormack 1110 Medical Campus Rd. Suite 130 Hagerstown, MD 21742</b>								
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

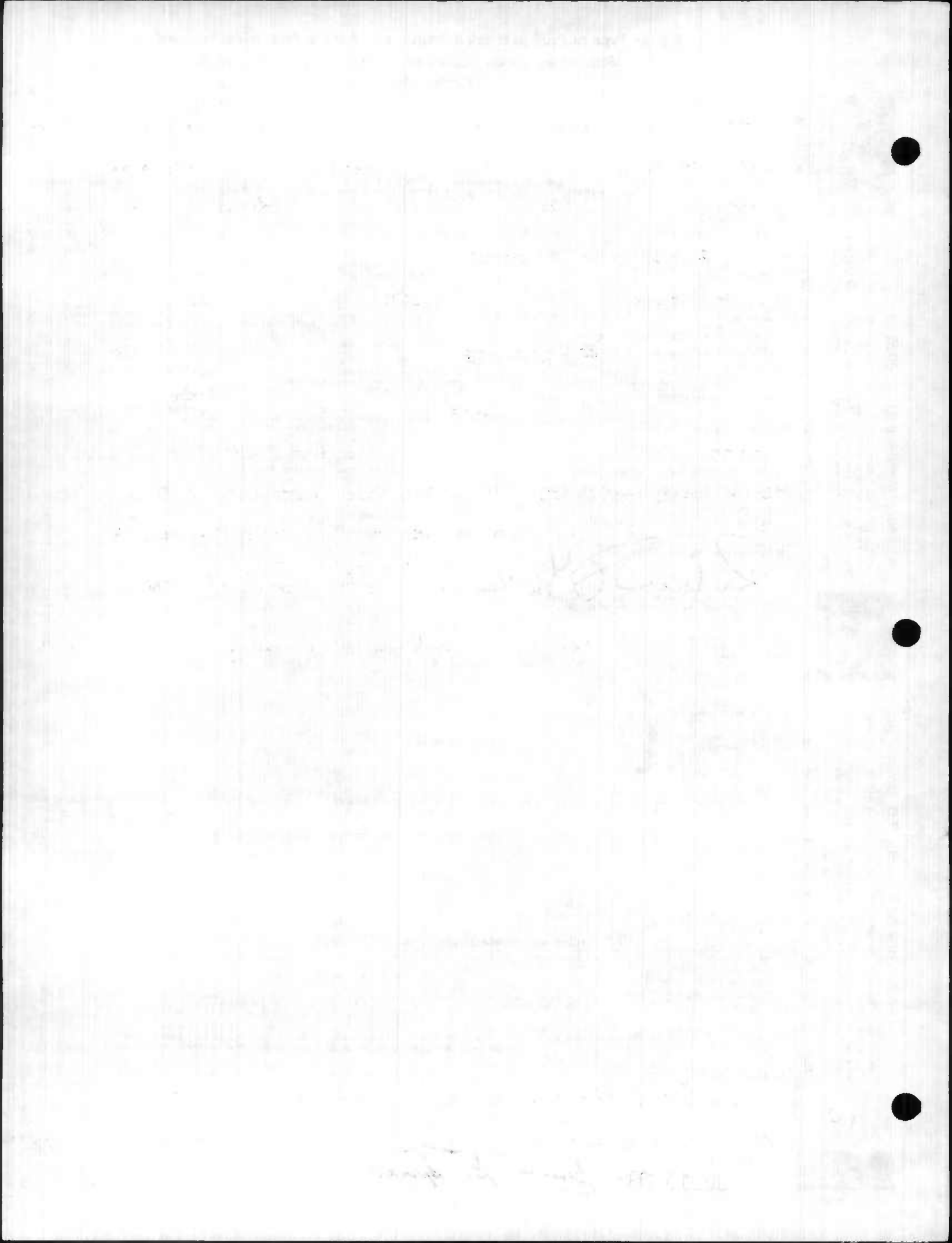
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22276

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NAOMI LANE</b>		2. Date of Death Month Day Year <b>JULY 13, 1999</b>		3. Time of Death <b>9:15AM</b>
	4e. Facility Name (If not institution, give street and number) <b>603 N. LINWOOD AVENUE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>260-28-1429</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>SEPT. 27, 1913</b>		9. Birthplace (State or Foreign Country) <b>GEORGIA</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. State <b>MARYLAND</b>	10b. County <b>N/A</b>	<b>BALTIMORE</b>		
	10e. Street and Number <b>603 N. LINWOOD AVE</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>AFRO-AMERICAN</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4TH</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>RESTAURANT OWNER</b>		16b. Kind of Business/Industry <b>SELF EMPLOYED</b>
	17. Father's Name (First, Middle, Last) <b>LESTER MINCEY</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MAGGIE ALMOND</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>JANNIE GUNN/ DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>603 N. LINWOOD AVENUE BALTO, MD. 21205</b>		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. PLEASANT Cem.</b>		20c. Location - City or Town, State <b>CLAYTON GEORGIA</b>
	21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs</i>		22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME</b> <b>1412 E. PRESTON STREET BALTO, MD. 21213</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death  <b>3 years</b> <b>5 years</b>
	e. <b>aortic stenosis</b> Due to (or as a consequence of):				
	b. <b>hypertension</b> Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Kimberly S. Peairs MD</i>		29c. License number <b>D47546</b>		29d. Date signed (Month, Day, Year) <b>7/14/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KIMBERLY S. PEAIRS ; 601 North Caroline Street ; 7th floor Johns Hopkins Outpatient Center, Baltimore MD 21287</b>					
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22277

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGUERITE V. MURRAY

2. Date of Death

Month Day Year  
July 13 1999

3. Time of Death

3:42AM

4e. Facility Name (If not Institution, give street and number)

Milchrist Center

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

526-03-3516

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Feb. 18, 1916

9. Birthplace (State or Foreign Country)

ARIZONA

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8820 Walther Blvd. Apt 1314

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

computer instructor

16b. Kind of Business/Industry

UNION New Jersey

17. Father's Name (First, Middle, Last)

William Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Florence Cottrell

19a. Informant's Name/Relationship (Type, Print)

Nancy A. Murray

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9602 Heather Green DR. Manassas, Va. 20112

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel-Belair

Date

July 13 1999

20c. Location - City or Town, State

Forest Hill, Md

21. Signature of Funeral Service Licensee

Keista S. Wells

22. Name and Address of Facility

Evans Funeral Chapel  
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. obstructive lung disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

26. Place of Death (Check only one)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Anthony Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

July 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley G Bmc 6701 N. Charles St. Balto. Md 21208

State Registrar

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

Bonnie B. Sparks

MARGUERITE MURRAY July 13, 1999  
Baltimore, Maryland 21215-0020 03424

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7/15/10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22278

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Maiolino</b>				2. Date of Death Month <b>7</b> Day <b>12</b> Year <b>99</b>		3. Time of Death <b>7:05 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Howard County Hospital</b>				4b. City, Town, or Location of Death <b>Columbia MD</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>099-03-5641</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05-16-1912</b>	9. Birthplace (State or Foreign Country) <b>ITALY</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>ELLICOTT CITY</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. Street and Number <b>3356 CHATHAM ROAD</b>				10f. Zip Code <b>21043</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (1-4 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>ROCCO MAFFEI</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>MARIA FINCHETTI</b>				
19a. Informant's Name/Relationship (Type, Print) <b>ANGELA REPETTI (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12009 METTEE ROAD MARRIOTTSTVILLE, MD 21104</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CRST LAWN MEM. GARDENS</b>		Data <b>7/17/99</b>		20c. Location - City or Town, State <b>MARRIOTTSTVILLE, MD</b>		
21. Signature of Funeral Service Licensee <b>Joseph J. Keelner</b>				22. Name and Address of Facility <b>LORING BYERS FUNERAL DIRECTORS, INC. 8728 LIBERTY ROAD RANDALLSTWON, MD 21133</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiopulmonary Arrest</b> Due to (or as a consequence of): <b>b. Intracranial Hemorrhage</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <b>~5 hours</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Catherine Hogerty MD</b>				29c. License number <b>D47749</b>		29d. Date signed (Month, Day, Year) <b>7-13-99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Catherine Hogerty MD</b>								
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature <b>B. Spach</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22279

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Josephine Barbara Marzec

2. Date of Death  
Month Day Year

JULY 11, 1999

3. Time of Death

1015AM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

170-26-5131

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 11, 1931

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1522 Ingalls Road

10f. Zip Code

21061

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Wojciech L. Marzec

18. Mother's Name (First, Middle, Maiden Surname)

Anastasia Antos

19a. Informant's Name/Relationship (Type, Print)

Gregory W. Marzec/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1522 Ingalls Road Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven mem. Pk.

Date

July 14, 1999

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

D. L. Ebaugh

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home P.A.  
421 Crain Hwy. S.E. Glen Burnie, MD 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

30 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ACUTE PULMONARY EDEMA

Due to (or as a consequence of):

2 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. H. Schuchter MD

29c. License number

D28221

29d. Date signed (Month, Day, Year)

July 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEL SCHUCHTER MD NORTH ARUNDEL HOSPITAL

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22280

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mae Elizabeth McCloskey					2. Date of Death Month Day Year July 13, 1999		3. Time of Death 2:00 PM		
	4a. Facility Name (If not institution, give street and number) 1488 Thies Dr.					4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 220-30-2053		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) June 23 1935		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10e. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Pasadena				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10f. Street and Number 1488 Thies Drive					10g. Zip Code 21122		10h. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Household			
17. Father's Name (First, Middle, Last) George A. Eckert					18. Mother's Name (First, Middle, Maiden Surname) Viola E. Bowling					
19a. Informant's Name/Relationship (Type, Print) William P. McCloskey spouse					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1488 Thies Drive Pasadena, MD 21122					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery		20c. Date 7/17/99		20d. Location - City or Town, State Glen Burnie, Maryland			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility STALLINGS FUNERAL HOME P.A. 3111 Mountain Road Pasadena, Maryland 21122					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Acute myocardial infarction</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 5 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Metastatic non-small cell carcinoma of the lung</u>							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number 022483		29d. Date signed (Month, Day, Year) July 14, 1999			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STUART JACOBS MD 200 Hospital Dr. Glen Burnie, MD 21061										
31. Date filed (Month, Day, Year) JUL 15 1999			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

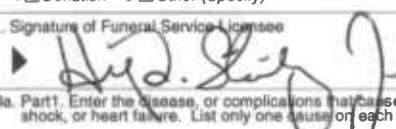




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22281

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CATHERINE T MOHAN</b>				2. Date of Death Month <b>July</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>1507</b>	
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>176-18-4681</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV 20 1919</b>	
	9. Birthplace (State or Foreign Country) <b>PHILA.PA.</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>664 Willowby Run</b>		10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>+5</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Professor</b>		16b. Kind of Business/Industry <b>Education</b>				
17. Father's Name (First, Middle, Last) <b>Cornelus Mohan</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Margaret Muldoon</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Robert Hallman son-in-law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>288 Scotts Glen Glen Burnie, MD 21061</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>		Date <b>7/17/99</b>		20c. Location - City or Town, State <b>Yeadon, PA</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Myocardial infarction</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number <b>36384</b>		29d. Date signed (Month, Day, Year) <b>7/11/99</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BASSIM BADRO 7845 OAKWOOD Rd. GLEN BURNIE, MD. 21061</b>								
31. Date filed (Month, Day, Year) <b>7/JUL 25 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22282

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Howard Vernon Martin, Sr.</b>				2. Date of Death Month Day Year <b>July 8, 1999</b>		3. Time of Death <b>8:52AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1205 Brandford Road</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-09-9228</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 9, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1205 Brandford Road</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Railroad Police Inspector</b>		16b. Kind of Business/Industry <b>Railroad</b>		17. Father's Name (First, Middle, Last) <b>William Martin</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Simmons</b>		19a. Informant's Name/Relationship (Type, Print) <b>Howard V. Martin, Jr./Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8906 Dolly Hyde Road - Union Bridge, Maryland 21791</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. Location - City or Town, State <b>7/12/99 Woodlawn, Maryland</b>		21. Signature of Funeral Service Licensee <b>Guarita R Thomas</b>		22. Name and Address of Facility <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue - Baltimore, Maryland 21229</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. <b>Cardiac arrest</b> Due to (or as a consequence of): <b>CHF</b> <b>HTN</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>MDD26294</b>		29d. Date signed (Month, Day, Year) <b>7/12/99</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DeLuisa, 1101 Maiden Choice Lane, Balto, MD. 21229</b>		31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature <b>[Signature]</b>			





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22283

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Miller

2. Date of Death

Month Day Year  
July 10 1999

3. Time of Death

3:03 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore  
city

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

216-36-7094

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
July 10, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1000 Franklin Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John C. Dumer

18. Mother's Name (First, Middle, Maiden Surname)

Lena Winklerman

19a. Informant's Name/Relationship (Type, Print)

Eric B. Miller (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

540 Anchor Drive Joppa, Md. 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Lawn Cemetery July 13, 1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Lassahn Funeral Home, Inc.

22. Name and Address of Facility

Lassahn Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Renal Failure

6 days

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Pseudomonas Pneumonia

21 days

Due to (or as a consequence of):

c. Candidal Orosespsis

21 days

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Justin C. Brown, MD

29c. License number

P13211

29d. Date signed (Month, Day, Year)

July 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Justin C. Brown 4009 Villa Nova Rd., Baltimore, Maryland 21207

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director


Medical Certification: To Be Completed by Physician/Medical Examiner



Reg. No. 99 22284

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>JAMES O. MILLER JR.</b>				2. Date of Death Month Day Year <b>JULY 8 1999</b>		3. Time of Death <b>10:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Church Home Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>	
5. Social Security Number <b>220-09-9661</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 19, 1924</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>6819 Boston Avenue</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Police Officer</b>		16b. Kind of Business/Industry <b>City Government</b>	
17. Father's Name (First, Middle, Last) <b>James Oliver Miller, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edna Ray Fields</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Robert F. Miller / Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6273 Branch Beech, Columbia, Maryland 21044</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Cemetery</b>		Date <b>7/12/99</b>		20c. Location - City or Town, State <b>Woodlawn, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229</b>			

To Be Completed by Funeral Director

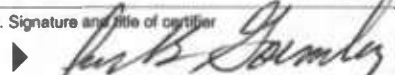
Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Myocardial Infarction</b> Due to (or as a consequence of):  b. <b>Ischemic Cardiac Disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>24 hrs</b>  <b>years</b>	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus, renal failure, malignant lymphoma of colon</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
---	--	--

29b. Signature and title of certifier 		29c. License number <b>DV8587</b>		29d. Date signed (Month, Day, Year) <b>July 8 1999</b>	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL GORMLEY 100 N BROADWAY BALTO MD 21231</b>					
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31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature 			
---	--	--	--	--	--

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22285

AMEND ITEM# 11 PER F.H. G773 7-20-99 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vincent Joshua O'Bryan				2. Date of Death Month Day Year JULY 9 1999		3. Time of Death 1440	
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-12-9089		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 8, 1924	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 4635 Wilkens Avenue				10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 2-27-43 to 3-7-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elevator Maintenance		16b. Kind of Business/Industry G.S.A.		
17. Father's Name (First, Middle, Last) William O'Brien				18. Mother's Name (First, Middle, Maiden Surname) Roberta Nicholson				
19a. Informant's Name/Relationship (Type, Print) Maxine V. O'Bryan (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4635 Wilkens Avenue - Baltimore, Maryland 21229				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Md Veterans Cemetery Crownsville		Date 7/13/99		20c. Location - City or Town, State Crownsville, Md
21. Signature of Funeral Service Licensee <i>Jackie H. Shannon</i>				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue-Baltimore, Maryland 21229				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Ventricular arrhythmia</i> Due to (or as a consequence of): b. <i>Acute MYOCARDIAL INFARCTION</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 1 hour 1 hour
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atherosclerotic cardiovascular disease</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Jerome I. Snyder M.D.</i>		29c. License number D 22648		29d. Date signed (Month, Day, Year) JULY 9, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jerome I. Snyder M.D. 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229</i>								
31. Date filed (Month, Day, Year) JUL 15 1999		32. Registrar's Signature <i>B. Sparks</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME O'BRYAN, V.

Division of Vital Records, P.O. Box 68760,

copy 3 sent 10/23/00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22286

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Robert</b>			2. Date of Death Month <b>July</b> Day <b>12</b> Year <b>1999</b>			3. Time of Death <b>7:15 PM</b>				
4a. Facility Name (If not institution, give street and number) <b>9000 Samaritan Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death				
5. Social Security Number <b>219-52-6641</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>50</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3 21 49</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
10a. State <b>MD</b>			10b. County			10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4823 Midwood Ave.</b>			10f. Zip Code <b>21212</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Fire man</b>			16b. Kind of Business/Industry <b>Baltimore city</b>				
17. Father's Name (First, Middle, Last) <b>Robert Lee Price</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Wilson</b>			19a. Informant's Name/Relationship (Type, Print) <b>Mildred Price - Mother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4825 Midwood Ave. 21212</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>			20c. Date <b>7/13/99</b>			20d. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Jeff Miller</b>			22. Name and Address of Facility <b>Jeff Miller Funeral Home</b>			22b. Address <b>1639 N. Broadway 21213</b>				

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>HEPATIC FAILURE</b> Due to (or as a consequence of): <b>HEPATOMA</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
--	--	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)  
Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death  
☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury  
**M**

28c. Injury at Work?  
☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

**Chirp Negrini, MD**

**P12563**

**July 12, 1999**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

**Clevia Negrini, MD 501 Loch Raven Blvd. Baltimore MD 21239**

31. Date filed (Month, Day, Year)

32. Registrar's Signature

**JUL 15 1999**

**James B. Sparks**

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22287

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Priscilla Pollard

2. Date of Death

Month Day Year  
July 11, 1999

3. Time of Death

0015

4a. Facility Name (If not institution, give street and number)

Deaton Specialty Hosp. 601 S. Charles St. 21230

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

249-78-7598

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 24, 45

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2428 W. Coldspring Lanr

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
09

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Lee Turner

18. Mother's Name (First, Middle, Maiden Surname)

Helen Clark

19a. Informant's Name/Relationship (Type, Print)

Nettie Scarborough(sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2428 W. Clodspring Ln. Balto.Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Star Cemetery 7-17-99

Date

20c. Location - City or Town, State

Balto., Md.

21. Signature of Funeral Service Licensee

Leonard M. Cole

22. Name and Address of Facility

Tri-State F/S Inc. 814 Upshur ST NW Wash. DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Carla S. Alexander MD

29c. License number

D27087

29d. Date signed (Month, Day, Year)

7/14/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CARLA S. ALEXANDER, MD UNIV MD 29 S. GREENE ST Suite 300, BALT, MD 21201

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

James B. Sparks

State Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1890

1890

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#19a perFH G773 7/15/99 EW

## Certificate of Death

Reg. No.

99 22288

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Ray Ruby

2. Date of Death

Month Day Year  
July 9, 1999

3. Time of Death

7:12 AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

096-26-9175

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 3, 1932

9. Birthplace (State or Foreign Country)

Chaneysville, PA.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Hydes

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13310 Bottom Road

10f. Zip Code

21082

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11 yrs.

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Excavator

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Hugh Ruby

18. Mother's Name (First, Middle, Maiden Surname)

Lilley Smith

19a. Informant's Name/Relationship (Type, Print)

~~Mrs. Susan King~~ Mrs Betty Lou Ruby (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13310 Bottom Road Hydes, MD. 21082

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Cem.

Date

7/12/99

20c. Location - City or Town, State

Chaneysville, PA.

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home  
11750 Belair Road Kingsville, MD. 2108723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M. Ruby

29c. License number

J30433

29d. Date signed (Month, Day, Year)

7/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M RUBY MD GRMC 6701 N CHARLES ST - BALTIMORE MD 21204

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

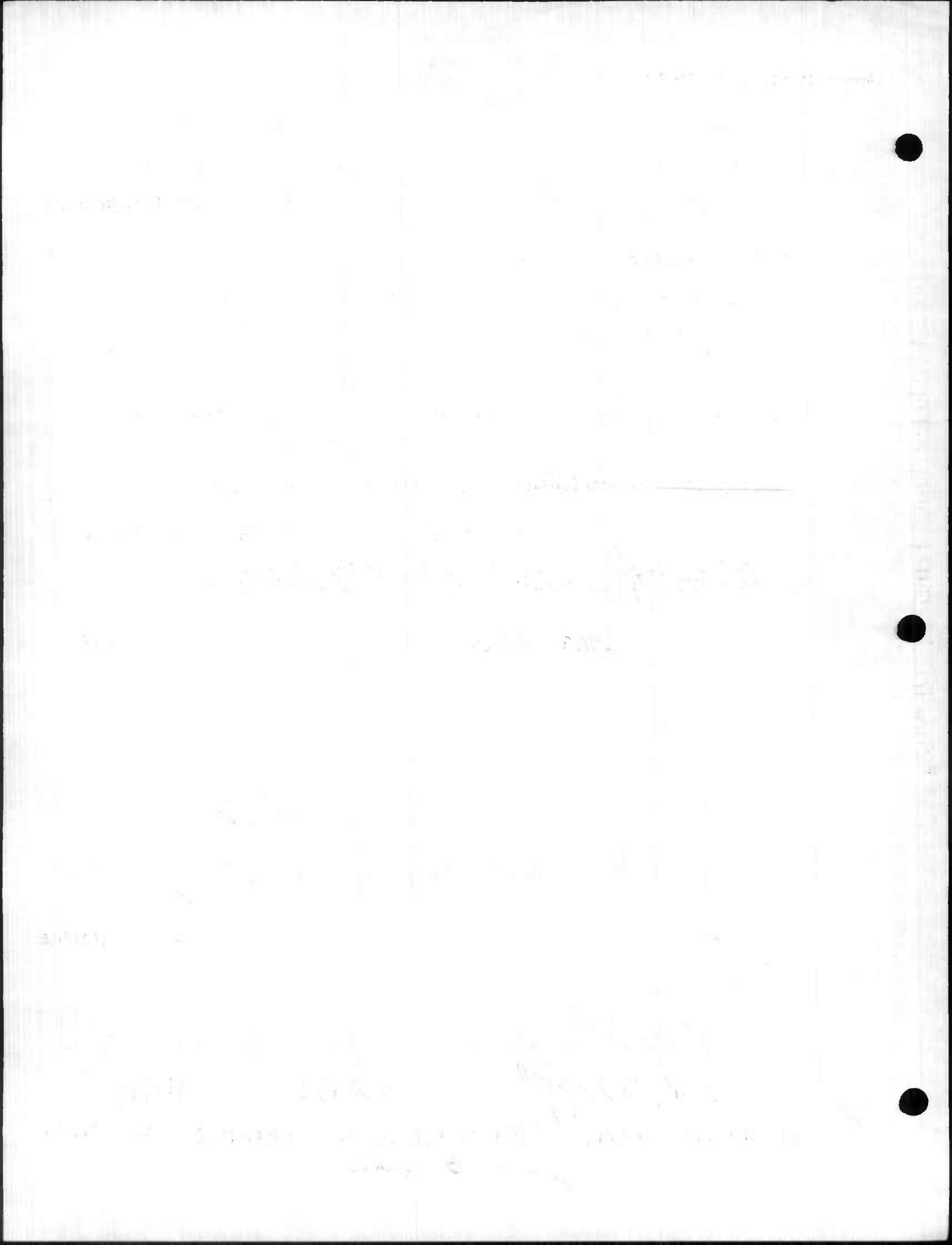
B. Sparks

State  
RegistrarRuby July 9, 1999 @ 7:12 AM  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
6063.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
KennethTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22289

AMENDED ITEM #19a PER INFO M. G773 7/26/99 AH

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard James Robbins, Sr.

2. Date of Death

Month Day Year  
July 11, 1999

3. Time of Death

2:30 PM

4a. Facility Name (If not institution, give street and number)

1504 Sulphur Spring Road

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-36-4164

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 10, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

10b. County

Maryland Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1504 Sulphur Spring Road

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cutter

16b. Kind of Business/Industry

Clothing Manufacture

17. Father's Name (First, Middle, Last)

William Robbins

18. Mother's Name (First, Middle, Maiden Surname)

Emma Litchlighter

19a. Informant's Name/Relationship (Type, Print)

MICHAEL J. ROBBINS/ SON

William J. Robbins, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1714 Hall Avenue, Lansdowne, Maryland 21227

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

7/13/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jackie D. Shannon

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue-Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. multiorgan failure

Due to (or as a consequence of):

b. Brainstem Glioma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Judith Lightsey MD

29c. License number

D40239

29d. Date signed (Month, Day, Year)

7-13-1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Judith Lightsey - Department of Oncology - 900 Catons Avenue - Baltimore, Md 21229

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 000-5.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)  
Raymond I. Strough Jr.

2. Date of Death  
Month: July, Day: 14, Year: 1999

3. Time of Death  
3:30 AM

4a. Facility Name (If not institution, give street and number)  
7722 Oakleigh Rd.

4b. City, Town, or Location of Death  
Parkville

4c. County of Death  
Baltimore

5. Social Security Number  
217-4-7808

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
69 Yrs.

8. Date of Birth (Month, Day, Year)  
July 23, 1929

9. Birthplace (State or Foreign Country)  
New York

10a. State  
Md.

10b. County  
Baltimore

10c. City, Town or Location  
Parkville

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
7722 Oakleigh Rd.

10f. Zip Code  
21234

10g. Citizen of What Country?  
USA

11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 11 Collage (1-4or 5+) -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Foreman

16b. Kind of Business/Industry  
Bethlehem Steel

17. Father's Name (First, Middle, Last)  
Raymond I. Strough, Sr.

18. Mother's Name (First, Middle, Maiden Surname)  
Mary A. Brown

19a. Informant's Name/Relationship (Type, Print)  
Cecelia A. Strough

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
7722 Oakleigh Rd. Baltimore, Maryland 21234

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Moreland Memorial Park

20c. Location - City or Town, State  
Parkville, Maryland

21. Signature of Funeral Service Licensee  
Heita S. Wells

22. Name and Address of Facility  
Evans Funeral Chapel  
8800 Hartford Rd. Baltimore, Md 21234

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Cardiac arrest  
Atherosclerotic heart disease

23b. Did tobacco use contribute to the cause of death?  
1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
J. Chang

29c. License number  
D165P7

29d. Date signed (Month, Day, Year)  
7/15/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
Dr. Paul Chang 5601 Loch Raven Blvd. Baltimore, Md.

31. Date filed (Month, Day, Year)  
JUL 15 1999

32. Registrar's Signature  
B. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 22291**  
**Certificate of Death** Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Pauline T. Serra</b>				2. Date of Death Month <b>JULY</b> Day <b>10</b> Year <b>1999</b>		3. Time of Death <b>10:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>CDOWELL CTB - GENESIS ELDER CARE</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>		
<b>Funeral Director</b>	5. Social Security Number <b>217-58-7887</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV 27 1907</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE CITY</b>		10c. City, Town or Location <b>BALTIMORE</b>		
<b>To Be Completed by Funeral Director</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>6411 BIRCHWOOD AVE.</b>		10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
<b>To Be Completed by Physician/Medical Examiner</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOME MAKER</b>		16b. Kind of Business/Industry <b>AT HOME</b>			
		17. Father's Name (First, Middle, Last) <b>EDWARD SAUERWALD</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARION UNKNOWN</b>		19a. Informant's Name/Relationship (Type, Print) <b>MICHAEL A. SERRA, SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6411 BIRCHWOOD AVE BALTIMORE, MD. 21214</b>	
<b>Physician /Medical Examiner</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MORELAND MEM. PARK</b>		20c. Location - City or Town, State <b>PARKVILLE, MD</b>		20d. Date <b>JULY 14, 1999</b>	
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES</b>		22b. Address <b>8800 HARFORD RD PARKVILLE, MD. 21234</b>			
<b>Physician /Medical Examiner</b>		23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <b>Cerebral Vascular Accident</b></p> <p>b. <b>Vitamin B12 deficiency</b></p> <p>c. </p> <p>d. </p> </div> <div style="width: 15%;"> <p><b>2 years</b></p> <p><b>3 years</b></p> </div> </div>						Approximate Interval Between Onset and Death	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
<b>Physician /Medical Examiner</b>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>Physician /Medical Examiner</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>Attending Physician</b>	
		29c. License number <b>053642</b>		29d. Date signed (Month, Day, Year) <b>July 11, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>XIAOMING ZHOU 3007 E Northler Park way Baltimore 21214</b>			
<b>State Registrar</b>		31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22292

## Certificate of Death

Reg. No.

AMENDED ITEM #7 PER FH G773 7/15/99 AH

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MAE SUE SANDERLIN

2. Date of Death

Month Day Year  
JULY 14 1999

3. Time of Death

11:45 AM

4a. Facility Name (If not institution, give street and number)

Church Home Hosp. 100N. Broadway 21231

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

218-26-2720

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 30, 24

9. Birthplace (State or Foreign Country)

Windsor, N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

424 Belnord Ave.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

Unemployed

17. Father's Name (First, Middle, Last)

David Sanderlin

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Basemore

19a. Informant's Name/Relationship (Type, Print)

Mary Curbeam (great-neice)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1907 Wadsworth Way Balto, Md. 21239

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Memorial Park

Date

7-17-99

20c. Location - City or Town, State

Woodlawn, Md.

21. Signature of Funeral Service Licensee

Leander M. Cole

22. Name and Address of Facility

814 Upshur St. N.W.  
Tri-State F/S Inc. Washington, D.C.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

30 min.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AGE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Sanderlin M.D.

29c. License number

D 31678

29d. Date signed (Month, Day, Year)

JULY 14, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SERGIO B. MATEO CHURCH HOSPITAL BALTO., MD 21231

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

Sanderlin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





WINIFRED SMITH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22293

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WINIFRED FALLEN SMITH				2. Date of Death Month Day Year JULY 11, 1999				3. Time of Death 3:10 PM		
	4a. Facility Name (If not institution, give street and number) 3706 WILDOR AVENUE				4b. City, Town, or Location of Death ROCKDALE				4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 232-01-7506		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) 11-29-1917		9. Birthplace (State or Foreign Country) WEST VIRGINIA		Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location ROCKDALE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 3706 WILDOR AVE.				10f. Zip Code 21244				10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) 1 YEAR				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) PATRICK FALLEN				18. Mother's Name (First, Middle, Maiden Surname) HAZEL McVICKOR						
	19a. Informant's Name/Relationship (Type, Print) CECELIA J. ENDERS (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 BESAN CT. BALTIMORE, MD 21244						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALT./WASH. CREMATORY		20c. Date 7/15/99		20d. Location - City or Town, State LAUREL, MARYLAND				
	21. Signature of Funeral Service Licensee  J. WAYNE OSTERLING				22. Name and Address of Facility LORING BYERS FUNERAL DIRECTORS, INC. 8728 LIBERTY ROAD RNADALLSTOWN, MD 21133						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. HEAD INJURIES Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) UNKNOWN		28b. Time of Injury UNKNOWN M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT FELL DOWN STAIRS			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3706 WILDOR AVENUE 21244							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  For J. L. Lockwood.				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 12, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JUL 15 1999		32. Registrar's Signature 									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22294

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Louise Schwindt

2. Date of Death  
Month Day Year

July 13, 1999

3. Time of Death

5:35 p.m.

4a. Facility Name (If not institution, give street and number)

Keswick Multi Care Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-16-8071

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 6, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

105 Keniworth Park Drive

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (14 or 5+)

4 yrs.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Assistant Principal

16b. Kind of Business/Industry

Baltimore City Schools

17. Father's Name (First, Middle, Last)

J. Clifton Hann

18. Mother's Name (First, Middle, Maiden Surname)

Florence Schaefer

19a. Informant's Name/Relationship (Type, Print)

William J. Schwindt / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1911 Kilbirnie Drive Germantown, Tennessee 38139

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

7/17/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1050 York Road

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Alzheimer's Disease

Due to (or as a consequence of):

10 Years

c. Parkinson's Disease

Due to (or as a consequence of):

10 Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

J. 2399

29d. Date signed (Month, Day, Year)

July 14, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles O'Donovan, III, M.D.

Keswick 700 W. 40th St.

Baltimore, Md.

21211

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

J. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

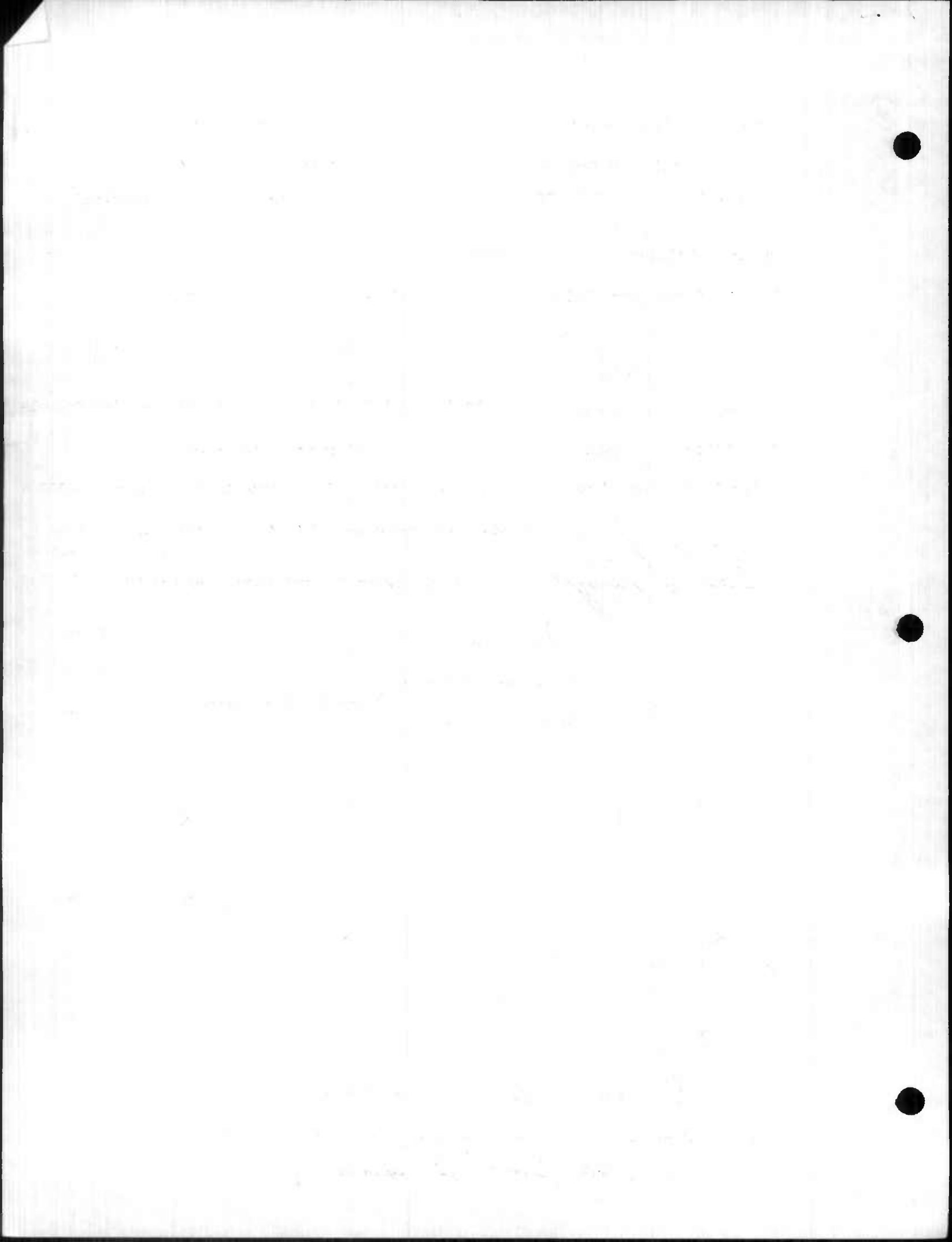
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22295

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEROME V. SHERMAN

2. Date of Death

JULY 13<sup>TH</sup> 1999

3. Time of Death

12:53 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE.

Funeral  
Director

5. Social Security Number

212-20-5773

6. Sex

1 ☐ M 2 ☐ F  
X

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 6, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3707 FIELDSTONE RD.

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

PROPRIETOR

16b. Kind of Business/Industry

JUNIOR DEPT. STORE

17. Father's Name (First, Middle, Last)

HYMAN

SHERMAN

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE

19a. Informant's Name/Relationship (Type, Print)

IDABELLE SHERMAN(WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3707 FIELDSTONE RD. RANDALLSTOWN, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHEVRA AHAVAS CHESD

Date

7/14/99

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. GANGRENE OF RIGHT FOOT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

END STAGE RENAL DISEASE.

CORONARY ARTERY DISEASE.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

HOUSE PHYSICIAN

29c. License number

D 42723.

29d. Date signed (Month, Day, Year)

JULY 13<sup>TH</sup> 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVVERA HALLI M HARISHA

3745 FOXFORD STREAM ROAD BALTIMORE MD 21236.

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22296

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>REUBEN SAWDAYE</b>		2. Date of Death Month <b>JULY</b> Day <b>11</b> Year <b>1999</b>		3. Time of Death <b>11:00 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>3609 ANTON FARMS ROAD</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>247.04.0387</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>FEB. 19, 1941</b>		9. Birthplace (State or Foreign Country) <b>IRAQ</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>3709 MICHELLE WAY</b>			10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INDUSTRIAL HYGIENIST</b>		16b. Kind of Business/Industry <b>DEFENSE U.S. GOVT. - DEPT. OF</b>	
17. Father's Name (First, Middle, Last) <b>MENASHI SAWDAYE</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>FRIDA MAZEN</b>		
19a. Informant's Name/Relationship (Type, Print) <b>ESTHER SAWDAYE / WIFE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3709 MICHELLE WAY - BALTIMORE, MD 21208</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH EL MEMORIAL PARK</b>		20c. Location - City or Town, State <b>7/13/99 RANDALLSTOWN, MD</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. <i>Cardiac Arrhythmia</i> Due to (or as a consequence of): b. <i>Arteriosclerotic CardioRenal Vascular Disease</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Local Street</i>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Charles F. O'Donnell MD</i>		29c. License number <b>D-09383</b>		29d. Date signed (Month, Day, Year) <b>July 14, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles F. O'Donnell MD 111 Hamlet Hill Rd Baltimore Md 21210</b>					
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature <i>B. Sparks</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



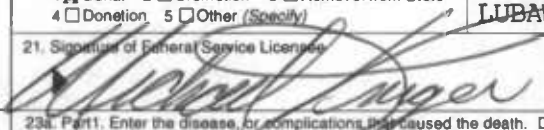


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22297

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JACOB STANGEN</b>		2. Date of Death Month <b>JULY</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>8:50 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>BRIGHTWOOD MERIDIAN NURSING CENTER</b>		4b. City, Town, or Location of Death <b>LUTHERVILLE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>080-18-4670</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>AUG. 5, 1924</b>		9. Birthplace (State or Foreign Country) <b>NY</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>6202 GREENSPRING AVENUE</b>		10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BIOLOGY TEACHER</b>		16b. Kind of Business/Industry <b>EDUCATION</b>	
17. Father's Name (First, Middle, Last) <b>SAM STANGEN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH PAKULA</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MARJORIE JOAN STANGEN / WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6202 GREENSPRING AVENUE - BALTIMORE, MD 21209</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LUBAWITZ NUSACH ARI (NER)</b>		20c. Location - City or Town, State <b>7/14/99 ROSEDALE, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one condition on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardio-Pulmonary Arrest</b> Due to (or as a consequence of): b. <b>Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): c. <b>Sickle Cell Anemia Syndrome</b> Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Harold B. Chen MD</b>		29c. License number <b>D21680</b>	
29d. Date signed (Month, Day, Year) <b>7/12/99</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>6217 Park Heights Avenue 21215</b>			
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22298

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frederick Herman Sack				2. Date of Death Month Day Year JULY 9, 1999				3. Time of Death 10:55PM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-03-2831		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) February 7, 1911		9. Birthplace (State or Foreign Country) Baltimore, Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore County				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 8800 Walther Blvd. Apartment 2301				10f. Zip Code 21234		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aircraft Tool Engineer				16b. Kind of Business/Industry Martin Marietta			
	17. Father's Name (First, Middle, Last) Charles Christian George Sack				18. Mother's Name (First, Middle, Maiden Summa) Mary Ellen Schafemann					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Dr. George Sack Jr. (Nephew)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Aintree Road Baltimore, Maryland 21286					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery July 13, 1999		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee <i>Robert Joseph Chiriac</i>				22. Name and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) BILATERAL EXTENSIVE PNEUMONIA  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE CARDIOMYOPATHY										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>goginder P mehta m.d.</i>				29c. License number D 41410		29d. Date signed (Month, Day, Year) July 9th, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204										
31. Date filed (Month, Day, Year) JUL 15 1999		32. Registrar's Signature <i>B. Sparks</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 22299

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>JOHN M. TAMBERRINO</u>				2. Date of Death Month <u>07</u> Day <u>09</u> Year <u>99</u>		3. Time of Death <u>1705</u>
	4a. Facility Name (If not institution, give street and number) <u>UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE BALTIMORE</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>219-26-4188</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>58</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>11-30-1940</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>		
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <u>Maryland</u>	10b. County <u>Baltimore</u>	10c. City, Town or Location <u>Reisterstown</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <u>1031 Green Hill Farm Road</u>		10f. Zip Code <u>21136</u>		10g. Citizen of What Country? <u>U. S. A.</u>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>Viet Nam</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u></u>		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Computer Analyst</u>		16b. Kind of Business/Industry <u>Federal Government</u>		
	17. Father's Name (First, Middle, Last) <u>Nicholas T. Tamberino</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Sue J. Vecchio</u>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Mrs Gloria J. Tamberino (Wife)</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1031 Green Hill Farm Rd., Reisterstown, Md. 21136</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u></u>		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Gardens Of Faith Cemetery</u>		20c. Location - City or Town, State <u>7-13-99 Overlea, Maryland</u>		
	21. Signature of Funeral Service Licensee <u>Wallace S. Brooks, Jr.</u>		22. Name and Address of Facility <u>Ruck Towson Funeral Home, Inc.</u> <u>1050 York Road, Towson, Md. 21204</u>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <u>STROKE</u> Due to (or as a consequence of): b. <u>HYPERTENSION</u> Due to (or as a consequence of): c. <u></u> Due to (or as a consequence of): d. <u></u>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>NONE</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u></u>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u></u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u></u>		28d. Describe how injury occurred <u></u>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Andrew Wackett MD</u>		29c. License number <u>12617</u>		29d. Date signed (Month, Day, Year) <u>07/09/99</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Andrew Wackett, M.D. 29 S. Greene St., Balto., Md. 21201</u>							
31. Date filed (Month, Day, Year) <u>JUL 15 1999</u>		32. Registrar's Signature <u>James B. Sparks</u>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22300

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRENE TAYLOR</b>		2. Date of Death Month Day Year <b>JULY 10, 1999</b>		3. Time of Death <b>10:00 AM</b>
	4e. Facility Name (If not institution, give street and number) <b>3601 CLARKS LANE #524</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>214-18-6022</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Month Days If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 28, 1922</b>
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>3601 CLARKS LANE #524</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>
	16b. Kind of Business/Industry <b>OWN HOME</b>		17. Father's Name (First, Middle, Last) <b>ISRAEL WEINBERG</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE SCHERR</b>
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>IRA TAYLOR / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>539 PRINCETON ROAD - HINSDALE, IL 60521</b>		
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW CEMETERY</b>		20c. Location - City or Town, State <b>7/14/99 BALTIMORE, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>myocardial infarction</b> Due to (or as a consequence of):  b. <b>coronary artery disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death  <b>1 hour</b>  <b>20 years</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>hd. D20604</b>		29d. Date signed (Month, Day, Year) <b>7/12/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Richard A. Berg, MD #450, 10755 Falls Rd., Lutherville, Md 21093</b>					
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22301

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dennis Richard Turner

2. Date of Death

Month Day Year  
JULY 14, 1999

3. Time of Death

10:45 AM

4a. Facility Name (If not institution, give street and number)

1545 Henryton Road

4b. City, Town, or Location of Death

Marriottsville

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

161-40-4859

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APR 17, 1947

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Marriottsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1545 Henryton Rd.

10f. Zip Code

21104

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Technician DOD

16b. Kind of Business/Industry

U. S. Government

17. Father's Name (First, Middle, Last)

Glenn Vincent Turner

18. Mother's Name (First, Middle, Maiden Surname)

Lucille V. Murphy

19a. Informant's Name/Relationship (Type, Print)

Dorothy J. Turner - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1545 Henryton Rd., Marriottsville, Md. 21104

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Pk.

Date

7/16/99

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.  
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. RENAL CELL CARCINOMA

Approximate Interval Between Onset and Death

6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28768

29d. Date signed (Month, Day, Year)

7/14/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 N. WOLFE ST #173 BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

7/14 JUL 15 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22302

AMENDED ITEM #2 PER MD G773 7/26/99 AH

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Minnie Umbach

2. Date of Death

Month Day Year  
July 6, 1999

3. Time of Death

5:10am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Millennium Health &amp; Rehabilitation Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

219-05-7236

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 26, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Anne Arundel10c. City, Town or Location  
Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7909 Oakwood Road

10f. Zip Code

21061

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Public Telephone Co.

17. Father's Name (First, Middle, Last)

Robert Pressler

18. Mother's Name (First, Middle, Maiden Surname)

Erna Hobel

19a. Informant's Name/Relationship (Type, Print)

Robert Krauss/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7909 Oakwood Road Glen Burnie, Maryland 21061

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lorraine Park Cemetery

Date

7/9/99

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hubbard Funeral Home, Inc.  
4107 Wilkens Avenue Baltimore, Maryland 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Respiratory Insufficiency

Due to (or as a consequence of):

hours

b.

Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

years

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

28. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

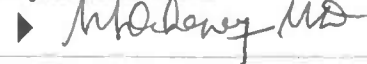
27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D-40521

29d. Date signed (Month, Day, Year)

July 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. OCHANAY

7845 Oakwood Road Suite 205  
Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MILATE

ALT

Sept 5, 1942 - 8

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State of Maryland / Department of Health and Mental Hygiene

99 22303

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GREGORY Allen WALTERS

2. Date of Death

Month Day Year  
JULY 8 1999

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

216 KEARNEY DRIVE

4b. City, Town, or Location of Death

JOPPA

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

218-72-0328

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

37

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 18 1962

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

JOPPA

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

216 KEARNEY DRIVE

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS.

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SELF EMP. - OWNER

16b. Kind of Business/Industry

SPORTING GOODS Co.

17. Father's Name (First, Middle, Last)

William J. WALTERS, JR.

18. Mother's Name (First, Middle, Maiden Surname)

Nancy L. DANIEL

19a. Informant's Name/Relationship (Type, Print)

LYNTHIA A. WALTERS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

216 KEARNEY DRIVE JOPPA, MARYLAND 21085

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garden of Faith Ceme.

Date

JULY 12 1999

20c. Location - City or Town, State

Rosedale, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVAN FUNERAL HOME  
8300 HARFORD ROAD PARKVILLE, MARYLAND 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myelogenous leukemia

Approximate Interval Between Onset and Death

9 months

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

history of Hodgkin's Lymphoma

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury of Work?

☐ Yes ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D35254

29d. Date signed (Month, Day, Year)

JULY 12 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carol Miller MD Johns Hopkins Ctr 600 N Wolfe St BALT MD 21287

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22304

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

PAULINE A. WILHELM

2. Date of Death

JULY

Day

9

Year

1999

3. Time of Death

5:45am

4a. Facility Name (If not institution, give street and number)

COLLEGE MANOR, INC

4b. City, Town, or Location of Death

LUTHERVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

219-10-7262

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

FEB. 1, 1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TIMONIUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27 NORTHWOOD RD.

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ASSISTANT SUPERVISOR

16b. Kind of Business/Industry

HUTZLER'S DEPT. STORE

17. Father's Name (First, Middle, Last)

SAMUEL PRICE

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE THOMPSON

19a. Informant's Name/Relationship (Type, Print)

RAYMOND L. WILHELM, SR, SPOUSE 27 NORTHWOOD RD. TIMONIUM, MD. 21093

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY MEM. Gdns.

Date

JULY 13, 1999

20c. Location - City or Town, State

TIMONIUM, MD

21. Signature of Funeral Service Licensee

Heidi S. Wells

22. Name and Address of Facility

EVANS CHAPEL OF CHIMES

2325 YORK RD. TIMONIUM, MD. 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bruce Rosenberg

29c. License number

D24121

29d. Date signed (Month, Day, Year)

7/9/99

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

BRUCE ROSENBERG 5150 FAIRMOUNT AVE TOWSON, MD 21286

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

B. S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22305

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Floyd White</b>				2. Date of Death Month <b>July</b> Day <b>09</b> Year <b>1999</b>		3. Time of Death <b>2:10P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>VAMHCS FORT HOWARD, FORT HOWARD, MD 21052</b>				4b. City, Town, or Location of Death <b>FORT HOWARD</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-12-1356</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8-13-21</b>	9. Birthplace (State or Foreign) <b>NORFOLK, VA</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4112 Belle Ave</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+) <b>na</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>		16b. Kind of Business/Industry <b>Baltimore City</b>		
17. Father's Name (First, Middle, Last) <b>John White</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Thomas Jones-Stepson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21207</b> <b>2029 Woodlawn Drive Apt I, Baltimore Md</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet</b>		Date <b>7/15/99</b>		20c. Location - City or Town, State <b>Owings Mills, Md</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LUNG CANCER WITH METASTASIS</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>3 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RENAL FAILURE, ANEMIA, LEUCOPENIA, ASBESTOSIS</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D14958</b>		29d. Date signed (Month, Day, Year) <b>July 9, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AURORA C. TAN, M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052</b>								
31. Date filed (Month, Day, Year) <b>JUL 15 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22306

AMENDED ITEMS #12 &amp; #15 PER FH G774 8/9/99 AH

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES THEODORE YORK

2. Date of Death

Month Day Year  
JULY 11, 1999

3. Time of Death

~ 830/AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Levering Ave. &amp; Route 95 north

4b. City, Town, or Location of Death

Elkridge

4c. County of Death

Howard

5. Social Security Number

124-38-5511

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 23, 1949

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5512 Selma Ave.

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 5/69-

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1/72

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Stock Broker

16b. Kind of Business/Industry

Stock Market

17. Father's Name (First, Middle, Last)

Theodore Frank York

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Graves

19a. Informant's Name/Relationship (Type, Print)

Linda York, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5512 Selma Ave., Arbutus, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Tyrone Union Cemetery

Date

7-14-99

20c. Location - City or Town, State

Tyrone, New York

21. Signature of Funeral Service Licensee

Sean S. Smiley

22. Name and Address of Facility

Ambrose Funeral Home

1328 Sulphur Spring Rd., Arbutus, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple trauma, (neck, trunk)

Approximate Interval Between Onset and Death

seconds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) street

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

July 11, 1999

28b. Time of Injury

~ 830 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

allowed self to fall over an overpass

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Bridge over Levering Ave - road interchange

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Levering Ave + Rte 95 N

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

Patrice A. Toye, MD

29c. License number

D31473

29d. Date signed (Month, Day, Year)

July 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICE A. TOYE, MD 4565 Hemlock Cone Way Elkridge City MD 21072

31. Date filed (Month, Day, Year)

JUL 15 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22307

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frederick Joseph Zimmerer				2. Date of Death Month Day Year July 13, 1999		3. Time of Death 12:10 AM	
	4a. Facility Name (If not institution, give street and number) Genesis Heritage Meridian Eldercare Ctr.				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-03-4126	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 23, 1915		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State Maryland	10b. County Baltimore	10c. City, Town or Location Dundalk			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 7606 Maple Road			10f. Zip Code 21222		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (14 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Manufacturing			
	17. Father's Name (First, Middle, Last) George Zimmerer				18. Mother's Name (First, Middle, Maiden Surname) Ida (Unknown)			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Anna Lackl Zimmerer Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7606 Maple Road Dundalk, Maryland 21222					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cem.		Date 7/17/1999		20c. Location - City or Town, State Dundalk, Maryland	
	21. Signature of Funeral Service Licensee <i>Stephanie Foster</i>		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222					
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END STAGE RENAL DISEASE Due to (or as a consequence of): b. DEMENTIA Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d. ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Carinder K. Tulle MD</i>		29c. License number D27188		29d. Date signed (Month, Day, Year) 7/13/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Carinder K. Tulle 2 Maryland Place Baltimore MD 21222</i>								
31. Date filed (Month, Day, Year) JUL 15 1999		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22308

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SALVADOR A. APPERTI</b>				2. Date of Death Month Day Year <b>June 27, 1999</b>		3. Time of Death <b>3:40 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>578-09-3515</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 3, 1906</b>	
	9. Birthplace (State or Foreign Country) <b>Canada</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Clinton</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6909 Friendship Road</b>		10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plasterer</b>		16b. Kind of Business/Industry <b>Construction</b>		17. Father's Name (First, Middle, Last) <b>Joseph Apperti</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Jean Lombardi</b>		19a. Informant's Name/Relationship (Type, Print) <b>Ralph Apperti (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6909 Friendship Road Clinton, Maryland 20735</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Date <b>June 30, 1999</b>		20d. Location - City or Town, State <b>Silver Spring, MD</b>		21. Signature of Funeral Service Licensee <b>Charles L. Bilanyer</b>		
22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ALTREROSCISCLTIC CARDIOVASCULAR DISEASE</b>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASPIRATION</b>		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23e. Were autopsy findings available prior to completion of cause of death? <b>N/A</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		24. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		27a. Date of Injury (Month, Day, Year)		27b. Time of Injury <b>M</b>		27c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27d. Describe how injury occurred		27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		27f. Location (Street and Number or Rural Route Number, City or Town, State)		28a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
28b. Signature and title of certifier <b>[Signature]</b>		28c. License number <b>D-18545</b>		28d. Date signed (Month, Day, Year) <b>JUNE 27, 1999</b>		29. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>P. WISOTSKY DAN 12070 OLD LINDS CENTER WARDEN, Md. 20602</b>		
30. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		31. Registrar's Signature <b>[Signature]</b>		32. Registrar's Signature <b>[Signature]</b>		33. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22309

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Allen Bruce, Sr.				2. Date of Death Month Day Year June 17, 1999		3. Time of Death 5:10PM		
	4a. Facility Name (If not institution, give street and number) 1700 Tioga Road				4b. City, Town, or Location of Death Ft. Washington		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 215-20-2732		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 8, 1925		
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Ft. Washington		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1700 Tioga Road		10f. Zip Code 20744		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insulation Installer		16b. Kind of Business/Industry Construction		17. Father's Name (First, Middle, Last) Robert Lee Bruce		18. Mother's Name (First, Middle, Maiden Surname) Mary Bellows	
19a. Informant's Name/Relationship (Type, Print) Kathy Hubbard (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Tioga Road Ft. Washington MD 20744		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington Natl. Cem.		20c. Location - City or Town, State June Date 1999 Suitland Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  LUNG CARCINOMA  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death 10 MONTHS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D43346		29d. Date signed (Month, Day, Year) 6/18/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Gupta M.D. 8926 Woodyard Road #201 Clinton, Maryland 20735	
31. Date filed (Month, Day, Year) JUN 24 1999		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified immediately.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22310

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Carroll

2. Date of Death

Month Day Year  
6 June 99

3. Time of Death

8:30 P

4a. Facility Name (If not institution, give street and number)

Bradford Oaks - 7520 Stratford

4b. City, Town, or Location of Death

Clinton, Md.

4c. County of Death

PG

5. Social Security Number

132 18 5431

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 26, 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10903 Rhodenda Place

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Switch Board Operator

16b. Kind of Business/Industry

Watervliet Arsenal

17. Father's Name (First, Middle, Last)

William Trotman

18. Mother's Name (First, Middle, Maiden Surname)

Grace Harris

19a. Informant's Name/Relationship (Type, Print)

Donald T. Carroll (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2705 Heartwood Cove Box 6C, Long Neck, Del 19966

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

July 3, 1999

20c. Location - City or Town, State

Troy, New York

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial infarction

Due to (or as a consequence of):

b. Coronary artery disease

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 hr

>10 yr

>10 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural

5 ☐ Pending investigation

2 ☐ Accident

6 ☐ Could not be determined

3 ☐ Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* MD Alteraviz

29c. License number

D-24535

29d. Date signed (Month, Day, Year)

6.25.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxmi Berwa, MD. 770 Old Branch Ave, Clinton, Maryland 20735

31. Date filed (Month, Day, Year)

JUN 25 1999

32. Registrar's Signature

*[Signature]* B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22311

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Sydnor Chichester Jr.				2. Date of Death Month Day Year June 23 1999		3. Time of Death 0130 AM	
	4a. Facility Name (If not institution, give street and number) 321 West Ave.				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 216 18 0650		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) Sept 24 1921	
	8. Birthplace (State or Foreign Country) Washington D.C.							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State Maryland		10b. County Calvert		10c. City, Town or Location Prince Frederick			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 321 West Ave				10f. Zip Code 20678		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) salesman		16b. Kind of Business/Industry Auto Supplies			
	17. Father's Name (First, Middle, Last) William Sydnor Chichester, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Ruth Noel Robinson			
	19a. Informant's Name/Relationship (Type, Print) Harriet D. Chichester - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 West Ave. Prince Frederick MD 20678			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Memorial Gardens		20c. Date June 25 1999		20d. Location - City or Town, State Dunkirk Maryland	
	21. Signature of Funeral Service Licensee B. Rausch				22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		26a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Bruce A. Silver, MD		29c. License number 021463		29d. Date signed (Month, Day, Year) 6-23-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce A. Silver, MD 110 Hospital Rd, Su. 110 Prince Frederick, MD 20678								
31. Date filed (Month, Day, Year) JUN 24 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22312

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>June H. Davis</b>				2. Date of Death Month Day Year <b>June 28, 1999</b>		3. Time of Death <b>8:00PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579 28 8363</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 21, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>Michigan</b>		10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Clinton</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8508 Denton Court</b>		10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Systems Analyst</b>		16b. Kind of Business/Industry <b>Federal Government</b>				
17. Father's Name (First, Middle, Last) <b>Orville Thomas Hicks</b>				18. Mother's Name (First, Middle, Maiden Sumama) <b>Verna Agnes Dudash</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mark B. Davis (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8508 Denton Court, Clinton, Maryland 20735</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Washington National Cemetery</b>		20c. Location - City or Town, State <b>Suitland, Maryland</b>		20d. Date of Disposition <b>July 2, 1999</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. <b>PNEUMONIA</b> Due to (or as a consequence of): <b>BRONCHOGENIC CARCINOMA</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Panding Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of Certifier 		29c. License number <b>D53885</b>		29d. Date signed (Month, Day, Year) <b>6/29/99</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. VENKAT S RAMANATHAN 7501 SURRATTS ROAD #307 CLINTON MD 20735</b>								
31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22313

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID LARRY GIBSON				2. Date of Death Month Day Year JUNE 26, 1999		3. Time of Death 9:07 am	
	4a. Facility Name (If not institution, give street and number) 4313 Cassell Blvd.				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 228 72 4056		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) July 22, 1948	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland		10b. County Calvert		10c. City, Town or Location Prince Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4313 Cassell Blvd.		10f. Zip Code 20678		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1968 1969		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electricians Helper		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) Emily Elizabeth Gibson			
	19a. Informant's Name/Relationship (Type, Print) Linda D. Burns / sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4313 Cassell Blvd., Prince Frederick, MD 20678			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Asbury Cemetery		20c. Location - City or Town, State 6/30/99 Barstow, Maryland			
	21. Signature of Funeral Service Licensee B. Rausch				22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, MD 20676			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer							
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7 months							
	23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Physician /Medical Examiner	23d. Part IV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23e. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
	23f. Part VI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23g. Part VII. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
	23h. Part VIII. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23i. Part IX. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
	23j. Part X. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23k. Part XI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
	23l. Part XII. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23m. Part XIII. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
	23n. Part XIV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23o. Part XV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
	23p. Part XVI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23q. Part XVII. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
	23r. Part XVIII. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23s. Part XIX. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
	23t. Part XX. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23u. Part XXI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
	23v. Part XXII. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23w. Part XXIII. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Bruce A. Silver, M.D.				29c. License number 021463		29d. Date signed (Month, Day, Year) June 28, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce A. Silver, M.D., 110 Hospital Drive, Prince Frederick, MD 20678								
31. Date filed (Month, Day, Year) JUN 28 1999				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22314

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Richard Magaha Gaither 2. Date of Death Month Day Year July 2, 1999 3. Time of Death 1:48 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 470 W. Dares Beach Road #101 4b. City, Town, or Location of Death Pr. Frederick 4c. County of Death Calvert

5. Social Security Number 219-14-9496 6. Sex M 2 F 7. Age (In yrs. last birthday) 72 Yrs. 8. Date of Birth (Month, Day, Year) 7/12/26 9. Birthplace (State or Foreign Country) MD

Usual Residence of Decedent 10a. State MD 10b. County Calvert 10c. City, Town or Location Prince Frederick 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 470 W. Dares Beach Road #101 10f. Zip Code 20678 10g. Citizen of What Country? USA

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: white 14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) Franklin P. Gaither 18. Mother's Name (First, Middle, Maiden Surname) Mamie T. Magaha Stone

19a. Informant's Name/Relationship (Type, Print) Pearl B. Gaither/ spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) S. Memorial Gdns 20c. Location - City or Town, State 7/4/99 Dunkirk, MD

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond Funeral Home, PA P.O. Box 121, Dunkirk, MD 20754

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ca Lung Terminal Due to (or as a consequence of): b. CAD. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximately Interval Between Onset and Death 6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KIOUMARCE YAZDANI P.O. Box 70 Huntingtown, MD 20639

31. Date filed (Month, Day, Year) JUL 06 1999 32. Registrar's Signature Geneva S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 99 22315

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Reino H. Hendrickson</b>				2. Date of Death Month Day Year <b>June 26, 1999</b>				3. Time of Death <b>1 A.M.</b>										
	4a. Facility Name (If not institution, give street and number) <b>Livingston Health Care Center</b>				4b. City, Town, or Location of Death <b>Fort Washington</b>				4c. County of Death <b>Prince George's</b>										
Funeral Director	5. Social Security Number <b>182-07-1162</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 25, 1910</b>		9. Birthplace (State or Foreign Country) <b>Finland</b>										
	Usual Residence of Decedent																		
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Clinton</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number <b>7804 Westover Lane</b>				10f. Zip Code <b>20735</b>				10g. Citizen of What Country? <b>U.S.A.</b>											
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>											
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>				16b. Kind of Business/Industry <b>Carpentry Local #454</b>											
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Fanny Makala</b>															
19a. Informant's Name/Relationship (Type, Print) <b>Nancy I. Marshall (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7804 Westover Lane Clinton, Maryland 20735</b>															
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		Date <b>June 28, 1999</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>											
21. Signature of Funeral Service Licensee <b>Kelli R. Patter</b>				22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, Md 20735</b>															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Dehydration</b></td> <td>Approximate Interval Between Onset and Death <b>72</b></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>Alzheimer's dementia</b></td> <td><b>5yr</b></td> </tr> <tr> <td>c. <b>Cause of Death</b></td> <td><b>3yr</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <b>Dehydration</b>	Approximate Interval Between Onset and Death <b>72</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Alzheimer's dementia</b>	<b>5yr</b>	c. <b>Cause of Death</b>	<b>3yr</b>	d.	
Immediate Cause (Final disease or condition resulting in death)	a. <b>Dehydration</b>	Approximate Interval Between Onset and Death <b>72</b>																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>Alzheimer's dementia</b>	<b>5yr</b>																	
	c. <b>Cause of Death</b>	<b>3yr</b>																	
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of certifier <b>Dr. M. D. Attending</b>				29c. License number <b>D-24535</b>											
				29d. Date signed (Month, Day, Year) <b>6-28-99</b>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Laxmi N. Berwa M.D. 7700 Old Branch Avenue #C101 Clinton, Maryland 20735</b>																			
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>				32. Registrar's Signature <b>B. Sparks</b>															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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Handwritten text in the lower section of the page.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22316

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arelious Sidney Harmon, Jr.</b>				2. Date of Death Month Day Year <b>June 25, 1999</b>		3. Time of Death <b>1:12PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>046-14-0385</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 20, 1916</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Clinton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>11508 Keystone Avenue</b>				10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1935-1941</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bus Driver</b>		16b. Kind of Business/Industry <b>Metro - WashingtonDC</b>		
17. Father's Name (First, Middle, Last) <b>Arelious Sidney Harmen, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Missouri Mapp</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Thomas S. Harmon (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2743 Pinewood Drive Waldorf, Maryland 20601</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>Suitland, Maryland</b>		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): b. <b>PNEUMONIA</b> Due to (or as a consequence of): c. <b>SUBDURAL HEMATOMA</b> Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MYELOFIBROSIS</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>N/A</b>		28b. Time of Injury <b>N/A</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>N/A</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>N/A</b>					28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Victor E. Herry MD</b>		29c. License number <b>D209FC</b>		29d. Date signed (Month, Day, Year) <b>6/28/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VICTOR E. HERRY 9131 PISCATAWAY Rd SUITE 240 CLINTON MD 20735</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature <b>B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5+1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22317

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Francis Hall</b>				2. Date of Death Month Day Year <b>June 22, 1999</b>		3. Time of Death <b>7:25AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579-44-6604</b>		6. Sex <b>XX</b> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 20, 1934</b>	9. Birthplace (State or Foreign Country) <b>Washington DC</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Clinton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>6608 Horseshoe Road</b>				10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>X</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Real Estate Broker</b>		16b. Kind of Business/Industry <b>Self-employed</b>		
17. Father's Name (First, Middle, Last) <b>James Ernest Hall</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Frances Watts</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary E. Hall (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6608 Horseshoe Road Clinton, Maryland 20735</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Christ Episcopal Church Cem.</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Severe metabolic acidosis / ESRD</b> Due to (or as a consequence of): b. <b>respiratory failure</b> Due to (or as a consequence of): c. <b>Auto Myocardial Infarction</b> Due to (or as a consequence of): d. <b>Diabetes</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <b>N/A</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		10. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier 		29c. License number <b>D41580</b>		29d. Date signed (Month, Day, Year) <b>June 24, 1999</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>SCOTT KELSO 2203 SURREATS RD CLINTON, MD 20735</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>JUN 25 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

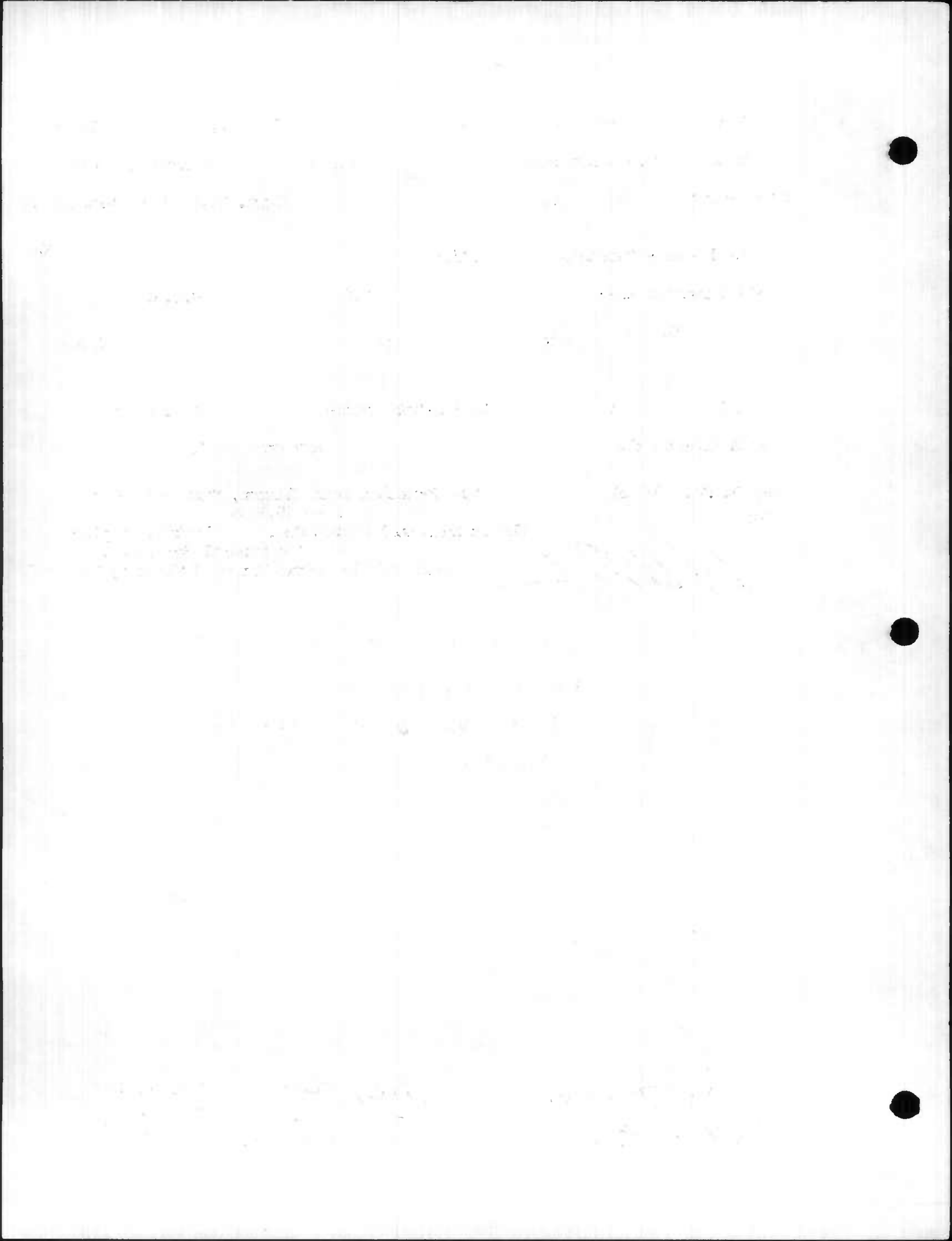
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22318

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Donald Mann Heizer, Jr.</b>				2. Date of Death Month <b>July</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>2325</b>	
	4a. Facility Name (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>578 30 9918</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 10, 1927</b>	
	9. Birthplace (State or Foreign Country) <b>Wash., D.C.</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>MD</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Dares Beach, Prince Frederick</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>139 Chesapeake Avenue</b>				10f. Zip Code <b>20678</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Real Estate Agent</b>		16b. Kind of Business/Industry <b>Sales</b>			
	17. Father's Name (First, Middle, Last) <b>Donald M. Heizer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Claxton</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Nancy Wease Heizer/ wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>139 Chesapeake Ave., Dares Beach, Prince Frederick MD 20678</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>			
	21. Signature of Funeral Service Licensee <b>Rausch</b>				22. Name and Address of Facility <b>Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, MD 20676</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ASCVD</b> Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Dr. Charles A. Judge</b>				29c. License number <b>029457</b>		29d. Date signed (Month, Day, Year) <b>7/2/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Charles A. Judge, M.D., Prince Frederick, Maryland 20678</b>								
31. Data filed (Month, Day, Year) <b>JUL 06 1999</b>				32. Registrar's Signature <b>Benita B. Sparks</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22319

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Preston J Jones

2. Date of Death

Month

Day

Year

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

Calvert County Nursing Center

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

219-16-1953

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 14, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3831 Capital Hill Lane

10f. Zip Code

20639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Preston G. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Harvey

19a. Informant's Name/Relationship (Type, Print)

Mildred K. Jones/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3831 Capital Hill Lane Huntingtown, MD 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Patuxent UM Church Cem.

Date

7/1/99

20c. Location - City or Town, State

Huntingtown, MD

21. Signature of Funeral Service Licensee

Bladye G. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Congestive heart failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Pomilla, M.D.

29c. License number

046314

29d. Date signed (Month, Day, Year)

6/26/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Paul Pomilla, M.D.

Prince Frederick, MD

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

Benita B. Spauld

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10/1/77

10/1/77

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State of Maryland / Department of Health and Mental Hygiene 99 22320

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pinkey Elizabeth Lancaster				2. Date of Death Month Day, Year July 02, 1999		3. Time of Death 5:05 A.M.	
	4a. Facility Name (If not institution, give street and number) 2120 Parkers Creek Road				4b. City, Town, or Location of Death Port Republic		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 216-76-6980		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 10, 1935	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Port Republic	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2120 Parkers Creek Road		10f. Zip Code 20676		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Willie Leroy Harrod, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Sarah Elizabeth Parran			
	19a. Informant's Name/Relationship (Type, Print) William S. Lancaster/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120 Parkers Creek Road Port Republic, MD 20676			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Solid Rock Church Cem.		Date 7/8/99		20c. Location - City or Town, State Port Republic, MD	
	21. Signature of Funeral Service Licensee Bladys G. Sewell				22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Organ System Failure Due to (or as a consequence of): End Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death							
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple CVA, Diabetes Mellitus, Hypertension, Coronary Artery Disease, Myocardial Infarction, Anemia, Gastritis Diabetic Gastropathy, Retinopathy, Neuropathy						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier D. J. Subba				29c. License number DS0963		29d. Date signed (Month, Day, Year) 7/3/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FULTON LUKBAN, M.D. 135W. DARES BEACH RD. #109 PRINCE FRED., MD 20678								
State Registrar	31. Date filed (Month, Day, Year) JUL 06 1999				32. Registrar's Signature B. Sparta			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hezekiah Mason</b>				2. Date of Death Month <b>June</b> Day <b>26</b> , Year <b>1999</b>		3. Time of Death <b>5:30 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>220 Mason Road</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>578-01-6992</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 23, 1907</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Prince Frederick</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>220 Mason Road</b>				10f. Zip Code <b>20678</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1943-</b> If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mover</b>			16b. Kind of Business/Industry <b>Moving Company</b>	
17. Father's Name (First, Middle, Last) <b>John Mason</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Smallwood</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lydia Gross/Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>220 Mason Road Prince Frederick, MD 20678</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Timothy Baptist Chr. Cem.</b>		20c. Location - City or Town, State <b>7/2/99 Amherst County, VA</b>		
21. Signature of Funeral Service Licensee <b>Blady a. Sewell</b>				22. Name and Address of Facility <b>Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cardio - Resp failure</b> Due to (or as a consequence of): b. <b>Normal Pressure Hydrocephalus</b> Due to (or as a consequence of): c. <b>vit B12 deficiency</b> Due to (or as a consequence of): d. <b>Depression</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Shah MD</b>		29c. License number <b>D 50290</b>		29d. Date signed (Month, Day, Year) <b>6/28/99</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dhiren Shah, M.D. 110 Hospital Road Prince Frederick, MD 20678</b>								
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>				32. Registrar's Signature <b>B. Sparks</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4+1





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22322

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances L. Jane Mihos				2. Date of Death Month Day Year June 25, 1999		3. Time of Death 4:30 AM	
	4a. Facility Name (If not institution, give street and number) Regency Nursing Home				4b. City, Town, or Location of Death Forestville		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577 09 9140		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Oct 4, 1917	
	9. Birthplace (State or Foreign Country) Washington DC		10a. State MD		10b. County P.G.		10c. City, Town or Location Forestville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2140 Brooks Drive		10f. Zip Code 20747		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Hechts Company			
	17. Father's Name (First, Middle, Last) Walter Reed Thomas				18. Mother's Name (First, Middle, Maiden Surname) Ruth Turner			
	19a. Informant's Name/Relationship (Type, Print) Nick Mihos (HUSBAND)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2140 Brooks Drive Apt #209, Forestville, Maryland 20747			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State June 28, 1999 Brentwood, Maryland			
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Richard A. Furson MD		29c. License number D02237 MD		29d. Date signed (Month, Day, Year) 6/25/99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Furson, MD 12825 Old Fort Rd Ft Wash MD 20744							
	31. Date filed (Month, Day, Year) JUN 29 1999		32. Registrar's Signature Benita B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22323

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>JAMES ROTH MARCH</b>			2. Date of Death Month <b>JUNE</b> Day <b>25</b> Year <b>1999</b>		3. Time of Death <b>6:30AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1134 AMBER WAY</b>			4b. City, Town, or Location of Death <b>OWINGS</b>		4c. County of Death <b>CALVERT</b>	
Funeral Director	5. Social Security Number <b>577-62-5951</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>APRIL 6, 1947</b>	9. Birthplace (State or Foreign Country) <b>WASHINGTON, DC</b>	
	Usual Residence of Decedant			10a. State <b>MARYLAND</b>		10b. County <b>CALVERT</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>OWINGS</b>			10d. Inland City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1134 AMBER WAY</b>	
	10f. Zip Code <b>20736</b>			10g. Citizen of What Country? <b>U. S. A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
	12. Was Decedant Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>VIETNAM</b>			13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>WHITE</b>		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COUNSELOR</b>		16b. Kind of Business/Industry <b>DRUG ADDICTION PROGRAM</b>	
	17. Father's Name (First, Middle, Last) <b>JOSEPH W. MARCH, JR.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>BETTY MAE LAING</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>BETTY M. MARCH/MOTHER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1134 AMBER WAY OWINGS, MARYLAND 20736</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD VETERANS CEMETERY</b>		20c. Location - City or Town, State <b>1,1999 CHELTENHAM, MARYLAND</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Endstage Cardiomyopathy</b> Due to (or as a consequence of): b. <b>Myotonic Dystrophy</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension; Cerebrovascular Accident</b>						
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 			29c. License number <b>D33723</b>		29d. Date signed (Month, Day, Year) <b>JUNE 25, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JONATHAN D. LOWENTHAL, M.D. 10845 TOWN CENTER BLVD. #204 DUNKIRK, MARYLAND 20754</b>							
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>			32. Registrar's Signature 				



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State of Maryland / Department of Health and Mental Hygiene 99 22324

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leonard Oliver Mallonee, Sr.</b>				2. Date of Death Month <b>JUNE</b> Day <b>20</b> Year <b>1999</b>		3. Time of Death <b>1620</b>
	4a. Facility Name (If not institution, give street and number) <b>10308 THRIFT ROAD</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGES</b>
Funeral Director	5. Social Security Number <b>577 36 1192</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 20, 1928</b>	9. Birthplace (State or Foreign Country) <b>Washington DC</b>
	Usual Residence of Decedent						
10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Clinton</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>10308 Thrift Road</b>				10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bureau of Engraving</b>		16b. Kind of Business/Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>Franklin W. Mallonee</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Foster</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Jeffrey Hook (STEPSON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15830 Sarah Court, Brandywine, Maryland 20613</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery</b>		Date <b>June 24, 1999</b>		20c. Location - City or Town, State <b>Cheltenham, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>• HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>D33954</b>		29d. Date signed (Month, Day, Year) <b>JUNE 21, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>							
31. Date filed (Month, Day, Year) <b>JUN 24 1999</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22325

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BERINICE MALLON</b>				2. Date of Death Month <b>June</b> Day <b>22</b> Year <b>1999</b>		3. Time of Death <b>2-50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GLADYS SPELMAN NURSING HOME</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PG COUNTY</b>	
Funeral Director	5. Social Security Number <b>579 26 4429</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 27, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Clinton</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6714 Eilerson Street</b>		10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>		17. Father's Name (First, Middle, Last) <b>Peter B. Jochum</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Peters</b>		19a. Informant's Name/Relationship (Type, Print) <b>Edward J. Mallon (HUSBAND)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6714 Eilerson Street, Clinton, Maryland 20735</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardiogenic Shock.</b> Due to (or as a consequence of): b. <b>Congestive Heart Failure</b> Due to (or as a consequence of): c. <b>Gastrointestinal bleed.</b> Due to (or as a consequence of): d. <b>Acute Renal Failure</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial fibrillation.</b> <b>Breast Cancer with metastasis</b> <b>Anemia, Hypoalbuminemia</b>		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospital side</b>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Nancy Timothy</b>		29c. License number <b>00052848</b>		29d. Date signed (Month, Day, Year) <b>6/22/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>NANCY K. TIMOTHY, 5807, ANNAPOLIS RD, HYATTESVILLE MD 20784</b>		31. Date filed (Month, Day, Year) <b>JUN 24 1999</b>		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results obtained.

2. The second part of the report deals with the specific work done during the year. It is a detailed account of the work done and the results obtained.

3. The third part of the report deals with the financial statement of the year. It is a summary of the income and expenditure of the year.

4. The fourth part of the report deals with the general remarks and conclusions. It is a summary of the work done and the results obtained.

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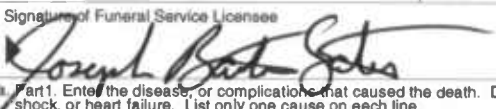
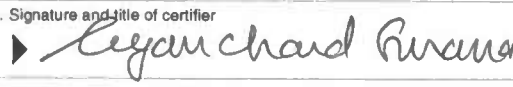
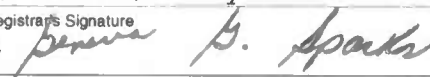
The fourth part of the report deals with the general remarks and conclusions. It is a summary of the work done and the results obtained.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 22326**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE RAYMOND MADIOU</b>				2. Date of Death Month <b>JUNE</b> Day <b>30</b> Year <b>1999</b>		3. Time of Death <b>10:10AM</b>		
	4e. Facility Name (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>PRINCE FREDERICK</b>		4c. County of Death <b>CALVERT</b>		
Funeral Director	5. Social Security Number <b>084-14-2320</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT. 29, 1922</b>		
	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>		10a. State <b>MARYLAND</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>CLARKSVILLE</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>7205 MEADOW WOOD WAY</b>		10f. Zip Code <b>21029</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W.II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INSURANCE ADJUSTER</b>		16b. Kind of Business/Industry <b>INSURANCE</b>					
17. Father's Name (First, Middle, Last) <b>MAURICE MADIOU</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA PASKURA</b>					
19a. Informant's Name/Relationship (Type, Print) <b>GENE F. MADIOU / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7205 MEADOW WOOD WAY CLARKSVILLE, MARYLAND 21029</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LEE CREMATORY</b>		Date <b>JULY 2, 1999</b>		20c. Location - City or Town, State <b>CLINTON, MARYLAND</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC CANCER</b> Due to (or as a consequence of): <b>b. CANCER OF LUNG</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>3 DAYS</b> <b>MORE THAN 10 YEARS</b>							
Part II. Other significant condition contributing to death but not resulting in the underlying cause given in Part I. <b>CORPULMONALE</b> <b>CORONARY ARTERY DISEASE</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 50653</b>		29d. Date signed (Month, Day, Year) <b>6-30-1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Gyan Surna, M.D., Deale, Maryland 20751</b>		31. Date filed (Month, Day, Year) <b>JUL 02 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Willie F. McGee

2. Date of Death

June 27, 1999

3. Time of Death

3:48 AM

4a. Facility Name (If not institution, give street and number)

Prince George's Community Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

207 22-0735

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 10, 1921

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1022 Drexelgate Lane

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

USAF

16b. Kind of Business/Industry

MILITARY

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lee McGee

19a. Informant's Name/Relationship (Type, Print)

Ingrid McGee (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1022 Drexelgate Lane, Upper Marlboro, Maryland 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

July 6, 1999

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Upper Gastrointestinal Bleeding  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE Atherosclerotic Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

TERRY A. JODRIE

29c. License number

D40324

29d. Date signed (Month, Day, Year)

6/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERRY A. JODRIE, M.D. 3001 HOSPITAL DRIVE, CHEVERLY MD 20785

31. Date filed (Month, Day, Year)

JUL 01 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

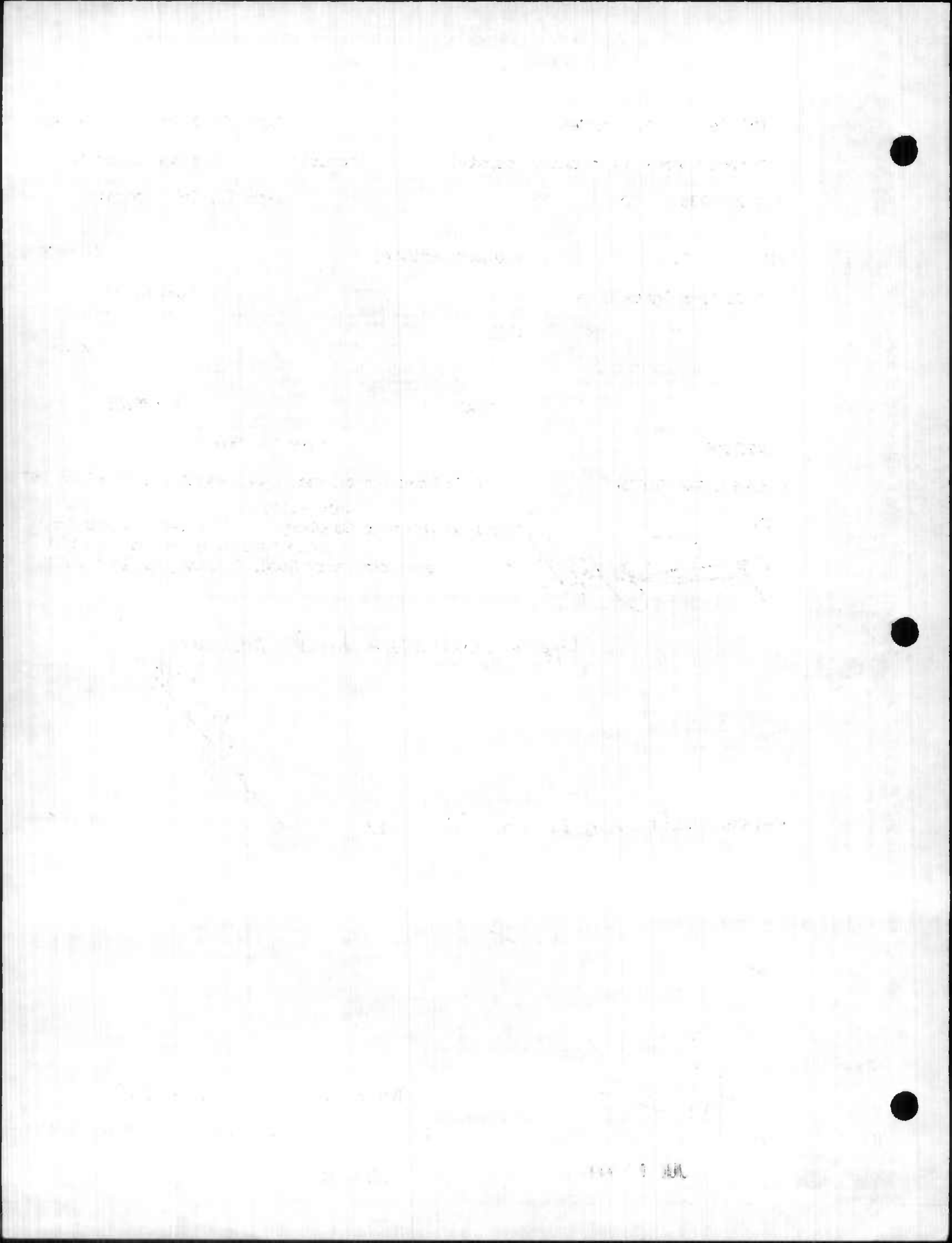
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22328

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Jean NEWMAN				2. Date of Death Month Day Year June 21, 1999		3. Time of Death 12:45 pm																	
	4a. Facility Name (If not institution, give street and number) 252 Macrae Ave.				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert																	
Funeral Director	5. Social Security Number 239 84 6367		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) May 30, 1936																	
	9. Birthplace (State or Foreign Country) TN		10a. State MD		10b. County Calvert		10c. City, Town or Location Prince Frederick																	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
	10e. Street and Number 252 Macrae Ave.				10f. Zip Code 20678		10g. Citizen of What Country? USA																	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white																	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife		16b. Kind of Business/Industry own home																	
	17. Father's Name (First, Middle, Last) Willis C Fields				18. Mother's Name (First, Middle, Maiden Surname) Nellie Macinturff																			
	19a. Informant's Name/Relationship (Type, Print) George E. Newman/husb.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above																			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Mem. Gardens		20c. Date 6-24-99		20d. Location - City or Town, State Dunkirk, MD																	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736																			
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
	<table border="0"> <tr> <td rowspan="4">                 Immediata Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last             </td> <td>e.</td> <td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</td> <td>YEARS</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3"></td> </tr> </table>								Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e.	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	YEARS	Due to (or as a consequence of):			b.	Due to (or as a consequence of):		c.	Due to (or as a consequence of):		d.		
Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e.	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	YEARS																					
	Due to (or as a consequence of):																							
	b.	Due to (or as a consequence of):																						
	c.	Due to (or as a consequence of):																						
d.																								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																								
29b. Signature and title of certifier 				29c. License number D40370		29d. Date signed (Month, Day, Year) 6/22/99																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Wisniewski, M.D. Prince Frederick, MD 20678																								
31. Date filed (Month, Day, Year) JUN 24 1999				32. Registrar's Signature 																				

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ENOS RAYMOND PUMPHREY</b>				2. Date of Death Month <b>JULY</b> Day <b>3</b> Year <b>1999</b>		3. Time of Death <b>1317</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST. MARY'S HOSPITAL</b>				4b. City, Town, or Location of Death <b>LEONARDTOWN</b>		4c. County of Death <b>ST. MARY'S</b>	
Funeral Director	5. Social Security Number <b>220-38-5819</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JULY 20, 1941</b>	
	9. Birthplace (State or Foreign Country) <b>WASHINGTON, DC</b>		10a. State <b>MARYLAND</b>		10b. County <b>ST. MARY'S</b>		10c. City, Town or Location <b>MECHANICSVILLE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>29748 BRUCE ROAD</b>		10f. Zip Code <b>20659</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>VIETNAM</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>GRAPHIC ARTIST/ACCOUNT EXEC.</b>		16b. Kind of Business/Industry <b>PRINTING</b>			
	17. Father's Name (First, Middle, Last) <b>ENOS RAY PUMPHREY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ARDITH ELIZABETH MILLER</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>NICOLE H. PUMPHREY/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>29748 BRUCE ROAD MECHANICSVILLE, MD 20659</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		20c. Location - City or Town, State <b>JULY 8, 1999 SUITLAND, MARYLAND</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736</b>			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIO-PULMONARY ARREST</b> Due to (or as a consequence of): <b>b. ATHERO-SCLEROTIC HEART DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BLADDER CARCINOMA.</b>							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>V. Anmangandla</b>				29c. License number <b>D26064</b>		29d. Date signed (Month, Day, Year) <b>7-6-99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>V. Sagar Anmangandla, M.D. Golden Beach Rd. Charlotte Hall, Maryland 20622</b>								
31. Date filed (Month, Day, Year) <b>JUL 07 1999</b>				32. Registrar's Signature <b>B. Sparks</b>				

15+1

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22330

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ada M. RAGANO

2. Date of Death

June 22, 1999

3. Time of Death

1945

4e. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

171-16-5565

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 18, 1907

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

470 West Dares Beach Rd. Apt. 308

10f. Zip Code

20678

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Batista

Rossi

18. Mother's Name (First, Middle, Maiden Surname)

Dena

unknown

19a. Informant's Name/Relationship (Type, Print)

Rocco Ragano/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8096 Windward Key Dr., Chesapeake Beach, MD 20732

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Calvary Cemetery

Date

6-28-99

20c. Location - City or Town, State

Pittsburgh, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rausch Funeral Home, Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure  
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

myocardial infarction

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Michael Brooks

29c. License number

A 39920

29d. Date signed (Month, Day, Year)

6/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1101 Maple Dr., Prince Frederick, MD 20678 J. Michael Brooks, M.D.

31. Date filed (Month, Day, Year)

JUN 24 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22331

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Catherine Annie Wright

2. Date of Death

June 19, 1999

3. Time of Death

12:06 P.M.

4a. Facility Name (If not institution, give street and number)

Heartland Health Care Center

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

5. Social Security Number

579 10 0341

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 8, 1912

9. Birthplace (State or Foreign Country)

Rhode Island

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Camp Springs

10d. Inside City Limits

1 ☐ Yes 2 ☒ No XX

10e. Street and Number

5622 Lansing Drive

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Patrick J. Etheridge

18. Mother's Name (First, Middle, Maiden Surname)

Annie M. Callahan

19a. Informant's Name/Relationship (Type, Print)

Ann Berry (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5622 Lansing Drive, Camp Springs, Md 20748

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory June 19, 1999

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

4 Days

b. Atrial Fibrillation

Due to (or as a consequence of):

Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown XX

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D19609

29d. Date signed (Month, Day, Year)

06.19.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman R. Tuli, MD 3503 Perry Street Suite B, Mount Rainier, Maryland 20712

31. Date filed (Month, Day, Year)

JUN 24 1999

32. Registrar's Signature

Benita G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 22332**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ULRIKE MARIA SCHAUM</b>				2. Date of Death Month Day Year <b>JUNE 24, 1999</b>		3. Time of Death <b>1941</b>	
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>131 01 9888</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 13, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>Austria</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>PA</b>	10b. County <b>Cumberland</b>	10c. City, Town or Location <b>Gardners</b>			10d. Inside City Limits <b>1 Yes 2 No</b>		
	10e. Street and Number <b>960 Myerstown Road</b>			10f. Zip Code <b>17324</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever In U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>			16b. Kind of Business/Industry <b>own home</b>		
	17. Father's Name (First, Middle, Last) <b>unknown Olmer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Beverly A. Spieler/daug-in-law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>962 Myerstown Rd., Gardners, PA 17324</b>			
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>6-26-99</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service licensee 				22. Name and Address of Facility <b>Rausch Funeral Home, Owings, MD 20736</b>			
	23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE ORGAN SYSTEM FAILURE</b>							
	Due to (or as a consequence of): <b>b. SEPSIS SYNDROME</b>							
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b>								
Due to (or as a consequence of): <b>d.</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CARDIAC ARRHYTHMIA, RESPIRATORY INSUFFICIENCY, HYPALBUMINEMIA, ENKEPHALOPATHY, THYROTOXICOSIS, ANAL STRICTURE, ILEUS</b>						23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		
						24a. Was an autopsy performed? <b>1 Yes 2 No</b>		
						24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>		
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>						
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. Signature and title of certifier 		29c. License number <b>D50963</b>		29d. Date signed (Month, Day, Year) <b>6/24/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>FULTON LUKBAN, MD, 135 W. DAVIS BECKARD, PRINCE FREDERICK, MD, 20678</b>								
31. Date filed (Month, Day, Year) <b>JUN 25 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22333

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Earl Taylor				2. Date of Death Month Day Year June 22, 1999				3. Time of Death 10:39 am		
	4a. Facility Name (If not institution, give street and number) 6815 Walke Road				4b. City, Town, or Location of Death Friendship				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 216 22 3295		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) July 29, 1927		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Friendship		
Usual Residence of Decedent											
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Friendship		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 6815 Walke Road				10f. Zip Code 20758				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-46			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) painter				16b. Kind of Business/Industry U.S. Government			
17. Father's Name (First, Middle, Last) John Taylor						18. Mother's Name (First, Middle, Maiden Surname) Caroline Augusta Fink					
19a. Informant's Name/Relationship (Type, Print) Lorraine W. Taylor/wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. James Epis. Church Cem.		Date 6-25-99		20c. Location - City or Town, State Lothian, MD			
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Long cancer  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D19838		29d. Date signed (Month, Day, Year) 6/23/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selonich, M.D. 900 Bestgate Rd. Annapolis, Md. 21401											
31. Date filed (Month, Day, Year) JUN 25 1999				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23 PART I PER MD G775 9-1-99 WR.

## Certificate of Death

Reg. No.

99 22334

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Luther Preston Toulson Sr</b>				2. Date of Death Month <b>June</b> Day <b>28</b> Year <b>1999</b>		3. Time of Death <b>4:15 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Corsica Hills Nursing Home</b>				4b. City, Town, or Location of Death <b>Centreville</b>		4c. County of Death <b>Queen Anne</b>	
Funeral Director	5. Social Security Number <b>217-36-2275</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 14, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Queen Anne</b>		10c. City, Town or Location <b>Centreville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>205 Armstrong Ave</b>		10f. Zip Code <b>21617</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Queen Anne County Hwy</b>			
	17. Father's Name (First, Middle, Last) <b>Herman Toulson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Beulah Potts</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Elsie Toulson/daughter-in-law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 Teats Branch Rd Sudlersville MD 21668</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Busick Cemetery</b>		20c. Date <b>07/01/99</b>		20d. Location - City or Town, State <b>Barclay, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fleegle &amp; Helfenbein Funeral Home P.A. Greensboro, Maryland 21639</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Uro sepsis</b> Due to (or as a consequence of): <b>BPH BENIGM PROSTATE HYPERTROPHY</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>ASCVD<sub>3</sub> / AFib / CVA @ Hemiplegia Expressive Aphasia / Refusal to take Meds</b>  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASCVD<sub>3</sub> / AFib / CVA @ Hemiplegia Expressive Aphasia / Refusal to take Meds</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D 50996</b>		29d. Date signed (Month, Day, Year) <b>6/28/99</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Neil Stoddard MD 100 Brown St. Chestertown MD 21620</b>			
	31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22335

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WENDELL FACKLER VOGELSONG</b>				2. Date of Death Month <b>JUNE</b> Day <b>22</b> Year <b>1999</b>		3. Time of Death <b>0640 a.m.</b>																											
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>																											
Funeral Director	5. Social Security Number <b>199-07-6323</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 7, 1915</b>																											
	10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>LaPlata</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																											
To Be Completed by Funeral Director	10e. Street and Number <b>9245 Sadie Lane</b>				10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>U.S.A.</b>																											
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>KOREAN</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Automobile</b>																											
	17. Father's Name (First, Middle, Last) <b>George Vogelsong</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unavailable</b>																													
	19a. Informant's Name/Relationship (Type, Print) <b>Wendy Crawford (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9245 Sadie Lane LaPlata Maryland 20646</b>																													
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Paxtang Cemetery</b>		Date <b>June 26, 1999</b>		20c. Location - City or Town, State <b>Harrisburgh PA</b>																											
	21. Signature of Funeral Director 				22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>																													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>MORE THAN 1 YEAR</b></td> </tr> <tr> <td>b.</td> <td><b>EMPHYSEMA</b></td> <td><b>MORE THAN 1 YEAR</b></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	<b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>	Approximate Interval Between Onset and Death <b>MORE THAN 1 YEAR</b>	b.	<b>EMPHYSEMA</b>	<b>MORE THAN 1 YEAR</b>	c.			d.															
	Immediate Cause (Final disease or condition resulting in death)	a.	<b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>	Approximate Interval Between Onset and Death <b>MORE THAN 1 YEAR</b>																														
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c.																																		
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<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b></td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death? <b>N/A</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <b>N/A</b> <input type="checkbox"/> Yes <input type="checkbox"/> No						
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<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury <b>M</b></td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
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29b. Signature and title of certifier 				29c. License number <b>D50653</b>		29d. Date signed (Month, Day, Year) <b>6-22-1999</b>																												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Gyan Surana, M.D. Prince Frederick, MD 20678</b>																																		
31. Date filed (Month, Day, Year) <b>JUN 25 1999</b>		32. Registrar's Signature 																																

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22336

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Billy Joe Venis, Sr.				2. Date of Death Month Day Year JUNE 29, 1999		3. Time of Death 2200
	4e. Facility Name (If not institution, give street and number) 8010 CARMELL DRIVE				4b. City, Town, or Location of Death FORESTVILLE		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 430-40-5318	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 4, 1927	9. Birthplace (State or Foreign Country) Oklahoma
	Usual Residence of Decedent						
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Forestville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 8010 Carmel Drive				10f. Zip Code 20747		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) N/A				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver		16b. Kind of Business/Industry DC Transit/Metro	
17. Father's Name (First, Middle, Last) Louie M. Venis				18. Mother's Name (First, Middle, Maiden Surname) Willie Lee Arnn			
19a. Informant's Name/Relationship (Type, Print) Bettie Venis (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8010 Carmel Drive Forestville MD 20747			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland State Veterans Cem.		20c. Location - City or Town, State Crownsville, Maryland	
21. Signature of Funeral Service Licensee S. Sitt				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier		29c. License number D33954		29d. Date signed (Month, Day, Year) JUNE 30, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CAEVEYLY, MARYLAND 20785							
31. Date filed (Month, Day, Year) JUL 01 1999		32. Registrar's Signature S. Sparks					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.



To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 22337**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVELYN WILLIAMS</b>				2. Date of Death Month Day Year <b>JULY 1, 1999</b>		3. Time of Death <b>07:20 am</b>															
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>															
Funeral Director	5. Social Security Number <b>219 58 8512</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept 4 1910</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>														
	Usual Residence of Decedent																					
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Chesapeake Beach</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
	10e. Street and Number <b>3202 Highview Road</b>				10f. Zip Code <b>20732</b>		10g. Citizen of What Country? <b>United States</b>															
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>secretary</b>			16b. Kind of Business/Industry <b>County Gov.</b>																
	17. Father's Name (First, Middle, Last) <b>Harvey Luther Bivens</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anne Barbara Wagner</b>																	
	19a. Informant's Name/Relationship (Type, Print) <b>Lucretia W. Fisher- daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3202 Highview Dr. Chesapeake Beach MD 20732</b>																	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Christ Episcopal Cemetery</b>		Date <b>July 3, 1999</b>		20c. Location - City or Town, State <b>Port Republic Maryland</b>															
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rausch Funeral Home PA 4405 Brookes Island Road Port Republic Maryland 20676</b>																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Congestive Heart Failure</b></td> <td>Approximate Interval Between Onset and Death <b>2-3 years</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b. <b>Ischemic cardiomyopathy</b></td> <td></td> </tr> <tr> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. <b>Coronary artery Disease</b></td> <td></td> </tr> <tr> <td>d. _____</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Congestive Heart Failure</b>	Approximate Interval Between Onset and Death <b>2-3 years</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):		b. <b>Ischemic cardiomyopathy</b>		Due to (or as a consequence of):		c. <b>Coronary artery Disease</b>		d. _____	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <b>Congestive Heart Failure</b>	Approximate Interval Between Onset and Death <b>2-3 years</b>																				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):																					
	b. <b>Ischemic cardiomyopathy</b>																					
	Due to (or as a consequence of):																					
	c. <b>Coronary artery Disease</b>																					
d. _____	Due to (or as a consequence of):																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal Failure</b> <b>Chronic Obstructive Pulm. Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>M.D. Dr. Anwar Munshi, M.D.</b>		29c. License number <b>D19427</b>		29d. Date signed (Month, Day, Year) <b>7/11/99</b>																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Anwar Munshi, M.D., Prince Frederick, Maryland 20678</b>																						
31. Date filed (Month, Day, Year) <b>JUL 02 1999</b>		32. Registrar's Signature 																				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22338

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nora Ann Ashley</b>				2. Date of Death Month Day Year <b>JULY 14, 1999</b>				3. Time of Death <b>3:10am</b>											
	4a. Facility Name (If not institution, give street and number) <b>2404 228th Street</b>				4b. City, Town, or Location of Death <b>Pasadena</b>				4c. County of Death <b>Anne Arundel</b>											
Funeral Director	5. Social Security Number <b>278-28-6233</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG 2, 1932</b>		9. Birthplace (State or Foreign Country) <b>Ohio</b>											
	Usual Residence of Decedent																			
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
10e. Street and Number <b>2404 228th Street</b>				10f. Zip Code <b>21122-1220</b>				10g. Citizen of What Country? <b>USA</b>												
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Games Dealer</b>				16b. Kind of Business/Industry <b>Casino</b>												
17. Father's Name (First, Middle, Last) <b>Hyman P. Collins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Brown</b>																
19a. Informant's Name/Relationship (Type, Print) <b>Dana L. Collins/son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2404 228th St. Pasadena, MD 21122-1220</b>																
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		Date <b>07/14/99</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>														
21. Signature of Funeral Service Licensee <b>Edward A. Gregorchik</b>				22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Lung Cancer</b></td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <b>2 months</b></td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	<b>Lung Cancer</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>2 months</b>	b.		c.		d.	
Immediate Cause (Final disease or condition resulting in death)	a.	<b>Lung Cancer</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>2 months</b>																
	b.																			
	c.																			
	d.																			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown																				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred												
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier <b>Onan M.D.</b>				29c. License number <b>D39505</b>		29d. Date signed (Month, Day, Year) <b>July 14, 1999</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Yudhishtha Markan. 1600 Chain Hwy, Glen Burnie, MD. 21061</b>																				
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>James B. Sparks</b>																		

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22339

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Michael Adams

2. Date of Death

Month  
JulyDay  
15Year  
1999

3. Time of Death

3:30 P.M.

4a. Facility Name (If not institution, give street and number)

VAMHS FORT HOWARD DIVISION

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

122-20-5845

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

05-21-29

9. Birthplace (State or Foreign Country)

BROOKLYN, NY

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

White Marsh

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6037 Loreley Beach Road

10f. Zip Code

21162

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1950/1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

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To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Insurance Claim Manager

16b. Kind of Business/Industry

Insurance Company

17. Father's Name (First, Middle, Last)

William P. Adams

18. Mother's Name (First, Middle, Maiden Surname)

Anna Hudson

19a. Informant's Name/Relationship (Type, Print)

Kenneth Murray/friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6037 Loreley Beach Rd. White Marsh, MD 21162

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 7/16/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CANCER, COLON WITH METASTASIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

One Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P COLOSTOMY AND ILEOSTOMY, S/P PROSTATECTOMY,

ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Aurora C. Tan, M.D.

29c. License number

D14958

29d. Date signed (Month, Day, Year)

July 15, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

AURORA C. TAN, M.D. 9600 NORTH POINTE ROAD, FORT HOWARD, MD 21052

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

S. Sparks

State  
Registrar

ADAMS, JOSEPH M.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

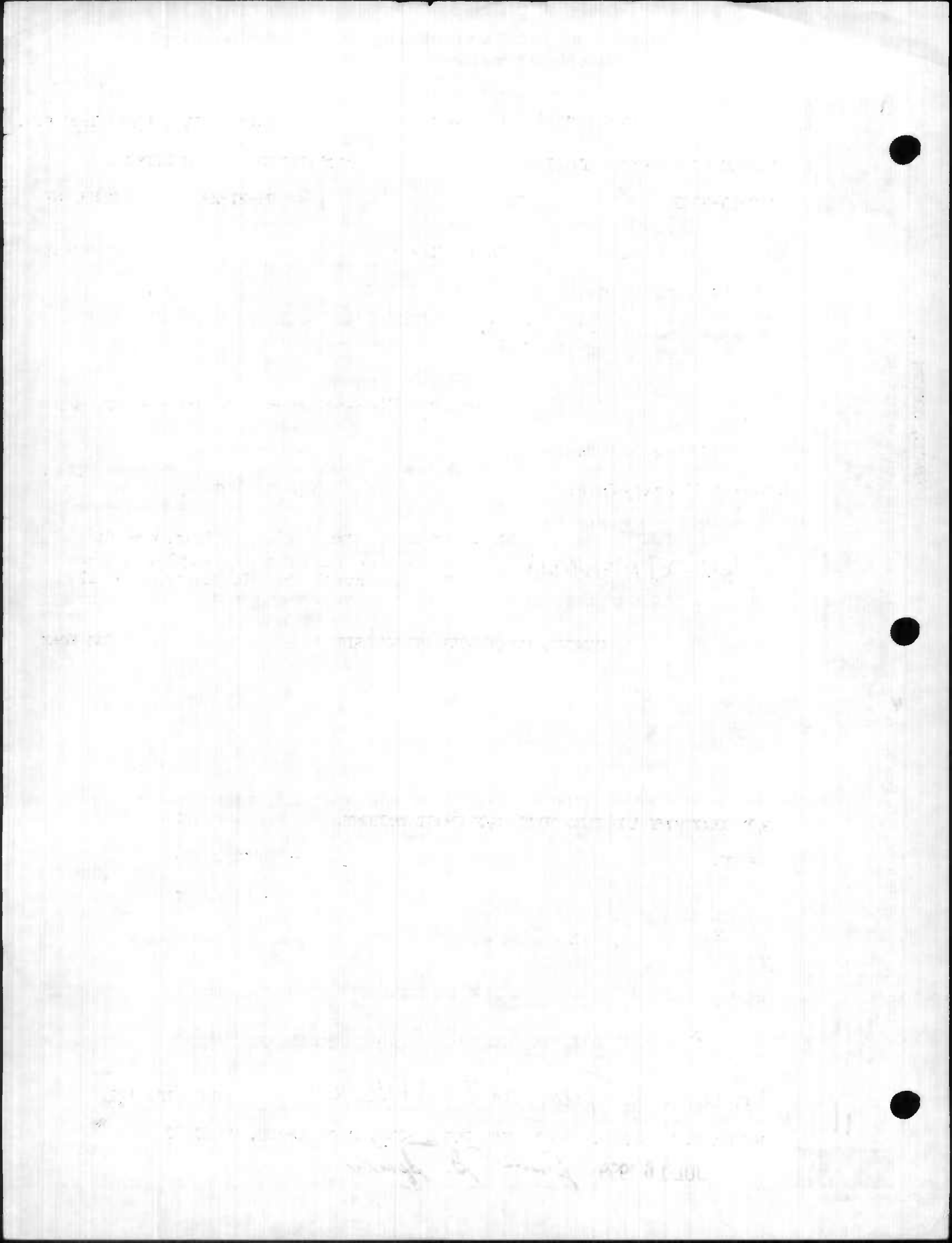
Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22340

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALTA

ARNOLD

2. Date of Death

Month Day Year  
JULY 5, 1999

3. Time of Death

11:35PM

4a. Facility Name (If not institution, give street and number)

FAIRFIELD NURSING CENTER

4b. City, Town, or Location of Death

CROWNSVILLE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

214-36-3322

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 8, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crownsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1454 Fairfield Loop Road

10f. Zip Code

21032

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Daniel Arnold

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Oakley

19a. Informant's Name/Relationship (Type, Print)

Thelma Wayson (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4632 Bayfield Road, Harwood, MD 20776

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Memorial Gardens 07/12

Date

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

Thomas Hardesty

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Coronary Suspect  
Due to (or as a consequence of):  
ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ELMO M. GAYOSO M.D.

29c. License number

D-19528

29d. Date signed (Month, Day, Year)

7/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1600 W. ... Bacto, Md. 21223

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

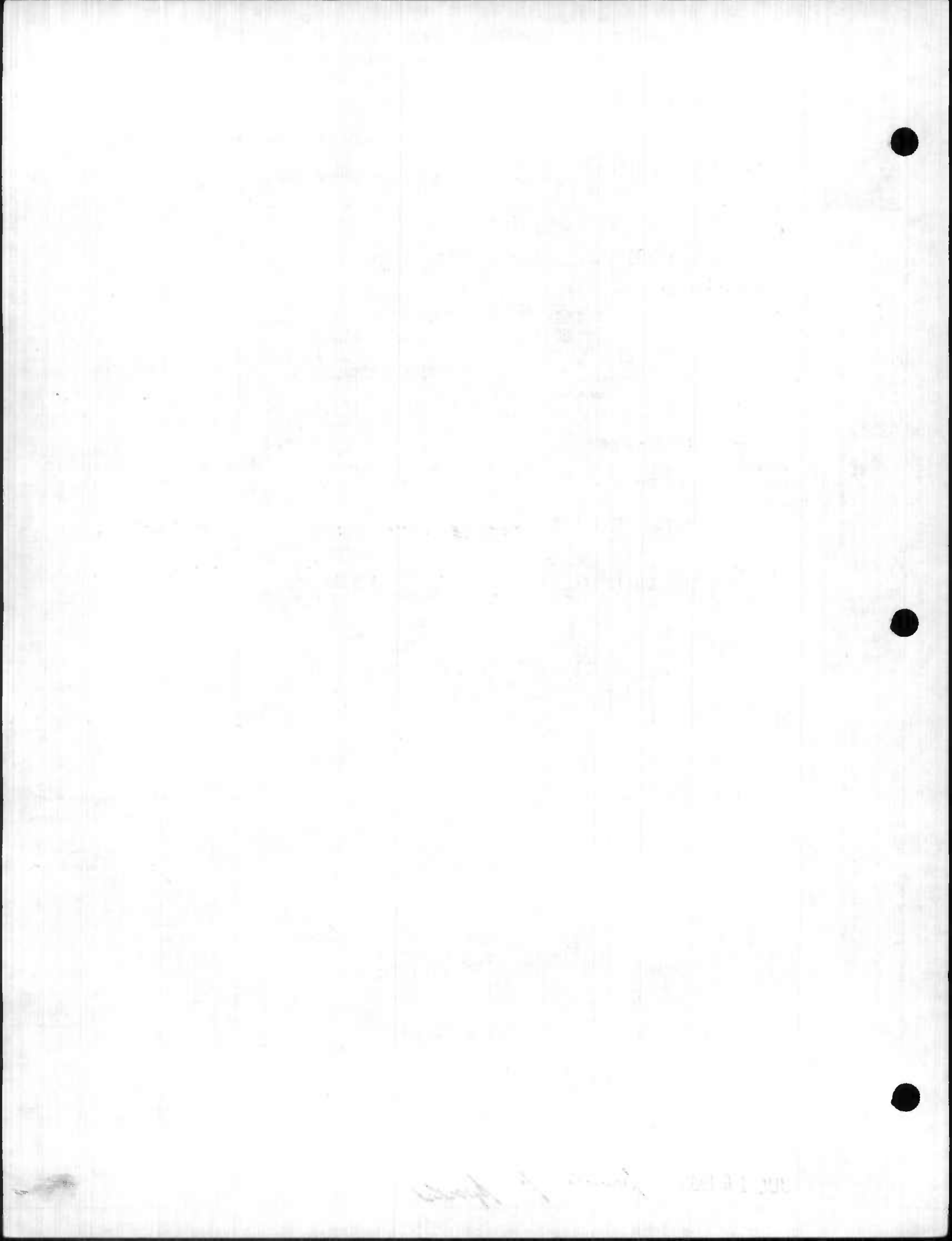
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22341

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna E. Bush

2. Date of Death

July 13 1999 2238

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

215-09-5736

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

October 22, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5549 Link Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Theodore Bachman

18. Mother's Name (First, Middle, Maiden Surname)

Sophia Bachman

19a. Informant's Name/Relationship (Type, Print)

William Bush

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6460 Skipton Dr. Hanover, Maryland 21076

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Memorial Park

Date

07/16/99

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

Sean A. Ambrose

22. Name and Address of Facility

Ambrose Funeral Home Inc.  
1328 Sulphur Spring Road, Arbutus, Maryland 2122723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Myocardial Infarction

Approximate  
Interval Between  
Onset and Death

1 hour

Due to (or as a consequence of):

b.

Atherosclerotic Heart Disease 1 year

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michelle Price, M.D.

29c. License number

D50778

29d. Date signed (Month, Day, Year)

July 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle Price 11055 Little Patuxent Pkwy Columbia, MD 21044

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

James B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22342

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>William Dailey Blumer</b>				2. Date of Death Month <b>July</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>8:45 pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Chesapeake Hospice House</b>				4b. City, Town, or Location of Death <b>Linthicum</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>262-30-0900</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 7, 1928</b>	
9. Birthplace (State or Foreign Country) <b>Florida</b>							

Funeral  
Director

To Be Completed by Funeral Director

Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Odenton</b>	
10e. Street and Number <b>572 Rita Drive</b>		10f. Zip Code <b>21113</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1946-47</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Jeweler</b>	
16b. Kind of Business/Industry <b>Jewelry</b>		17. Father's Name (First, Middle, Last) <b>William T. Blumer</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Dailey</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Tom W. Blumer (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>366 Hickory Nut Court, Pasadena, MD 21122</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem.</b>		20c. Location - City or Town, State <b>Crownsville, MD</b>	
21. Signature of Funeral Service Licensee <b>Thomas J. Hardesty</b>		22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401</b>			

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. <b>Rectal mass</b> Due to (or as a consequence of): <b>Coronary artery disease</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <b>Dr. Markan M.D.</b>		29c. License number <b>D39505</b>	
29d. Date signed (Month, Day, Year) <b>July 14, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Yudhishtira Markan 1600 Chain Hwy, Glen Burnie, MD 21061</b>	
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>B. Sparks</b>	

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 22343

COMPTEN  
BAGWELLPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Compton S. Bagwell, Jr.

2. Date of Death

Month  
JULY

Day

8, 1999

Year

3. Time of Death

4:23P.M.

4a. Facility Name (If not institution, give street and number)

2609 KEYWORTH AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

215-40-0857

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6-24-1940

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2609 Keyworth Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Store clerk

16b. Kind of Business/Industry

Market

17. Father's Name (First, Middle, Last)

Compton S. Bagwell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Louise Hallsworth

19a. Informant's Name/Relationship (Type, Print)

Nathaniel Walker Brother-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5426 Nelson Avenue Balts, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Zion Cemetery

Date

7-14-99

20c. Location - City or Town, State

Lansdown, Md

21. Signature of Funeral Service Licensee

M. Leary W. W. W.

22. Name and Address of Facility

March F. H. West  
4300 Wabash Avenue Balts, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

s.

Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Pestaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 9, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Joseph Pestaner

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

Benjamin S. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Group 2, number 100-1-106

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22344

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Michael Boyce

2. Date of Death  
Month Day Year

July 11 1999

3. Time of Death

6:03am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

294-56-0397

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 16, 1955

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22 Squanto Court

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1974-78

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Universal Contractors

17. Father's Name (First, Middle, Last)

Gerald R. Boyce

18. Mother's Name (First, Middle, Maiden Surname)

Antoinette Patricia Dorso

19a. Informant's Name/Relationship (Type, Print)

Rose M. Boyce ( Wife )

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

232-A Woodhill Drive Glen Burnie, Md. 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park 7/17/99 Glen Burnie, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Christina A. Hilton

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.  
237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Disease

Due to (or as a consequence of):

10 years

b. PNEUMONIA

Due to (or as a consequence of):

2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings evaluable prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

RD 196642

29d. Date signed (Month, Day, Year)

07-11-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Luis Lopez 9000 Franklin Square Drive Baltimore Maryland 21237

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Boyce, William

g

141



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22345

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Katie B. Battle</b>				2. Date of Death Month <b>July</b> Day <b>12</b> Year <b>1999</b>				3. Time of Death <b>07:03A</b>						
	4a. Facility Name (If not institution, give street and number) <b>MARYLAND GENERAL Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>City</b>						
Funeral Director	5. Social Security Number <b>225-32-7302</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8-23-1925</b>		9. Birthplace (State or Foreign Country) <b>VA</b>						
	10e. State <b>MD</b>				10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <b>3513 JoAnne Drive</b>				10f. Zip Code <b>21244</b>				10g. Citizen of What Country? <b>U.S.A</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6 grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COOK</b>				16b. Kind of Business/Industry <b>Hospital</b>							
17. Father's Name (First, Middle, Last) <b>William Miles</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Peir</b>											
19a. Informant's Name/Relationship (Type, Print) <b>Charles Booth - Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3513 JoAnne Drive Balto, Md 21244</b>											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT Zion Cemetery</b>				Date <b>7-16-99</b>		20c. Location - City or Town, State <b>Lansdown, Md</b>					
21. Signature of Funeral Service Licensee <b>John B. Johnson</b>				22. Name and Address of Facility <b>March F.H. West</b> <b>4300 Wabash Avenue Balto, Md</b>				21215							
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death) a. <b>Sepsis</b> Due to (or as a consequence of): b. <b>Bilateral Pneumonia</b> Due to (or as a consequence of): c. <b>Adult Respiratory Distress Syndrome</b> Due to (or as a consequence of): d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
												24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>James Tansinda</b>				29c. License number <b>P12678</b>				29d. Date signed (Month, Day, Year) <b>7/12/99</b>							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>James TANSINDA, M.D. c/o MARYLAND GENERAL Hospital</b>															
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>				32. Registrar's Signature <b>James B. Sparks</b>											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

JUL 1 1930



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22346

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wilbur Baldwin, Jr.

2. Date of Death

Month

Day

Year

July 12, 1999

3. Time of Death

6:35 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10 Bray Court

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

218-62-1293

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 16, 1951

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10 Bray Court

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telecommunication

16b. Kind of Business/Industry

Bell Atlantic

17. Father's Name (First, Middle, Last)

Wilbur C. Baldwin, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Doris Viehmeyer

19a. Informant's Name/Relationship (Type, Print)

Alexis Baldwin (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Bray Court, Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park 7/16/99 Elkridge, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home, Inc.

1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Respiratory failure

Due to (or as a consequence of):

2 days

b.

pancreatic cancer

Due to (or as a consequence of):

6 months

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jill Gilbert, MD

Fellow-medical oncology

29c. License number

D0053077

29d. Date signed (Month, Day, Year)

July 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jill Gilbert

600 North Wolfe St.

Rm 126 Baltimore, Md 21287

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

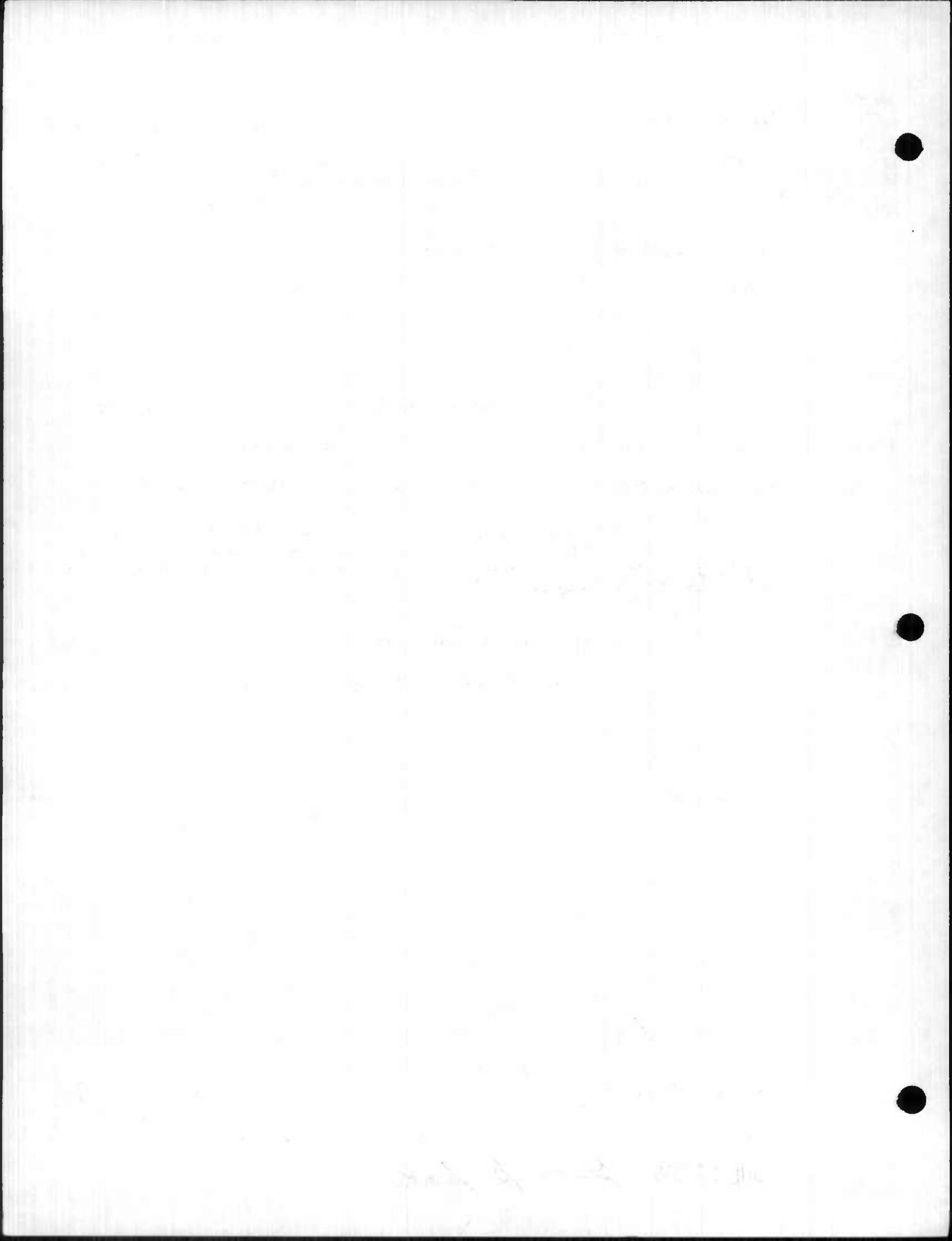
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22347

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bruce Lloyd Bailey

2. Date of Death

Month Day Year  
July 15, 1999

3. Time of Death

4:32 am

4a. Facility Name (If not institution, give street and number)

21 Compass Rd.

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218 92 0530

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

31

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 4, 1967

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21 Compass Rd.

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Folder Operator

16b. Kind of Business/Industry

Printing Co.

17. Father's Name (First, Middle, Last)

Harry L. Bailey

18. Mother's Name (First, Middle, Maiden Surname)

Suzane M. Henry

19a. Informant's Name/Relationship (Type, Print)

Judith G. Bailey (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Compass Rd. Baltimore, Md. 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Mem. Gardens 7/19/1999 Baltimore, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John W. Burkowski

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.  
1407 Old Eastern Avenue Essex, Md. 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

metastatic Small Cell Carcinoma of Liver

Approximate  
Interval Between  
Onset and Death

6 mo.

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

D45390

29d. Date signed (Month, Day, Year)

7/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYO MIN, M.D., 6830 HOSPITAL DR. #206, BALTIMORE, MD 21237

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

L. B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22348

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

EDWIN

LOUIS

BLAZEK

2. Date of Death

Month

Day

Year

July

14

1999

3. Time of Death

9:50 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

218-18-4755

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

07-21-1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther Blvd.

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Manager

18b. Kind of Business/Industry

Car/Chevrolet

17. Father's Name (First, Middle, Last)

Adolph

Blazek

18. Mother's Name (First, Middle, Maiden Summa)

Antonie

M.

Cernikova

19a. Informant's Name/Relationship (Type, Print)

Mr. Judson Blazek/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10697 Rich Neck Road Claiborne, Maryland 21264

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

07/16/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Stephen Coster

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyper cholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. A. M. M.D.

29c. License number

D47945

29d. Date signed (Month, Day, Year)

July 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harris Aleem MD 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

State Registrar

Blazek, Edwin  
Baltimore, Maryland 21215-0020Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22349

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LOUISE</b>		2. Date of Death Month <b>July</b> Day <b>14</b> Year <b>1999</b>		3. Time of Death <b>7:59 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>215-09-6118</b>	8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	6. Date of Birth (Month, Day, Year) <b>July 15, 1904</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Laurel</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>255 Sharptown South</b>		10f. Zip Code <b>20724</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>George Winkelman</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Katie Nagle</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Anna M. Naimaster (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>255 Sharptown South, Laurel, Maryland 20724</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		20c. Location - City or Town, State <b>7/17/99 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pulmonary Edema</b> Due to (or as a consequence of): <b>b. Congestive HEART FAILURE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>1 WEEK</b> <b>1 YEAR</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b> <b>DEMENTIA</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>RES-000</b>	
29d. Date signed (Month, Day, Year) <b>July 14, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LOUIS A. DIAZ, MD Johns Hopkins Hospital, Baltimore, MD</b>					
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22350

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) MARGARET S. BISHOP				2. Date of Death Month: July Day: 15 Year: 1999		3. Time of Death 1:07 AM	
4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
5. Social Security Number 224-34-3373		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 16, 1931	
9. Birthplace (State or Foreign Country) Virginia							

Usual Residence of Decedent			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. State Maryland	10b. County Harford	10c. City, Town or Location Aberdeen		

10e. Street and Number 1004 Stepney Road		10f. Zip Code 21001		10g. Citizen of What Country? U.S.A.	
---	--	------------------------	--	---	--

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
--	--	---	--	--	--	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
--	--	---------------------	--	--	--	--	--

17. Father's Name (First, Middle, Last) Oscar Akers		18. Mother's Name (First, Middle, Maiden Surname) Vivian Kingrea	
--	--	---	--

19a. Informant's Name/Relationship (Type, Print) James W. Bishop, Sr. (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Stepney Road, Aberdeen, MD. 21001	
--	--	---	--

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gardens		Date 7/17/99		20c. Location - City or Town, State Baltimore, Maryland	
---	--	---	--	-----------------	--	--	--

21. Signature of Funeral Service Licensee Brien A. Wellen		22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014	
--	--	---	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiogenic Hypotensive Shock Due to (or as a consequence of): b. Lymphoma Due to (or as a consequence of): c. Due to (or as a consequence of): d.			Approximate Interval Between Onset and Death 2 hours	
---	--	--	---	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
--	--	--	--

24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
---	--	---	--

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
---	--	---	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Selwyn E. Mahon MD		29c. License number RD 110650		29d. Date signed (Month, Day, Year) July 15, 1999	
---	--	---	--	----------------------------------	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Selwyn E Mahon 9000 Franklin Square Drive Baltimore Maryland 21237	
---	--

31. Date filed (Month, Day, Year) JUL 16 1999		32. Registrar's Signature B. Sparks	
--	--	--	--

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22351

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MADELINE

BAUHAUS

2. Date of Death

Month

Day

Year

JULY 11, 1999

3. Time of Death

7:15 AM

4a. Facility Name (If not institution, give street and number)

Lorien Nursing &amp; Rehabilitation Center

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

212-09-7284

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 18, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4614 Walther Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married2 ☐ Married3 ☒ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th. Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert

Pfarr

18. Mother's Name (First, Middle, Maiden Surname)

Marie

Beckett

19a. Informant's Name/Relationship (Type, Print)

Harry R. Bauhaus / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

647 Whittier Parkway Severna Park MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Mem. Gardens 7/14/99 Timonium MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller, Inc.

6415 Belair Road Baltimore MD 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Sepsis

Approximate Interval Between Onset and Death

14 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Abedata Ali Khan M.D.

29c. License number

D43323

29d. Date signed (Month, Day, Year)

JULY 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABEDATA ALI KHAN M.D.

10794 HICKORY RIDGE ROAD COLUMBIA MD 21044

31. Date filed (Month, Day, Year)

JULY 6 1999

32. Registrar's Signature

Benjamin D. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. 5

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that this certificate be completed and signed by the attending physician and the Funeral Director. After this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 22352

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROOSEVELT COUSER</b>				2. Date of Death Month <b>JULY</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>10:25</b>
	4a. Facility Name (If not institution, give street and number) <b>UNIV. OF MARYLAND MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>249-62-1437</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 7, 1937</b>	9. Birthplace (State or Foreign Country) <b>South Carolina</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
	10e. Street and Number <b>1534 Holbrook St.</b>			10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>African American</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Improvement</b>		16b. Kind of Business/Industry <b>Self-employed</b>		
	17. Father's Name (First, Middle, Last) <b>James Couser</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Carson</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (wife) <b>Mrs. Mary Couser</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>508 N. Carey St., Balto, Md. 21223</b>			
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion</b>		20c. Location - City or Town, State <b>Lansdowne, Md.</b>		
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>			22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave., Balto. Md. 21216</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CRYPTOCOCCAL MENINGITIS</b> Due to (or as a consequence of): b. <b>AIDS</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <b>1</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>C. Braud MD (BRAUD)</b>		29c. License number <b>Maryland State Identification Number P12372</b>		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>University of Maryland Medical Center 22. South Greene Street, Baltimore MD 21201</b>							
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>James B. Sparks</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AHD





Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Renee Joanne Cornelius

2. Date of Death

July 11, 1999

3. Time of Death

9:48 A.M.

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-64-5173

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs, last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 6, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

735 E. 36<sup>th</sup> St.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

File Clerk

16b. Kind of Business/Industry

Furniture Store

17. Father's Name (First, Middle, Last)

Eugene Hurst

18. Mother's Name (First, Middle, Maiden Surname)

Emma McCallum

19a. Informant's Name/Relationship (Type, Print)

Ms. Jocelyn Stills (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9903 Berliner Place #A Balto, Md. 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

7/20/99

20c. Location - City or Town, State

Owings Mills, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto, Md. 21216

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

CHRONIC NARCOTISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

X ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ InpatientX ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.X ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 12, 1999

30. Name and address of person who completed cause of death (Item 28e) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#28a-c,e,f perPhyG773 7/16/99 EW

## Certificate of Death

Reg. No.

99 22354

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Francis Oberlin Chapelle</b>				2. Date of Death Month <u>July</u> Day <u>11</u> Year <u>1999</u>		3. Time of Death <u>0625</u>	
4a. Facility Name (If not Institution, give street and number) <b>Union Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>376-14-0873</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT 9, 1915</b>	
9. Birthplace (State or Foreign Country) <b>Michigan</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6021 Lakeview Road</b>		10f. Zip Code <b>21210</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1969</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Officer and Priest</b>		16b. Kind of Business/Industry <b>Army and Episcopal Ministry</b>			
17. Father's Name (First, Middle, Last) <b>Francis LaChapelle</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Somers</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Suzanne Ellery Greene Chapelle/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6021 Lakeview Rd Baltimore, MD 21210</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		Date <b>7/12/99</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>		22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of):  <b>b. Sepsis</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>Cerebrovascular Accident</b> <b>Dementia</b> <b>Hypertension</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>July 10, 1999</b>		28b. Time of Injury <b>12:30</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, MD</b>					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Harrison Johnson MD</b>					
29c. License number <b>195768</b>		29d. Date signed (Month, Day, Year) <b>July 11, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Harrison Johnson, MD, CWH 2150 University Ave 21218</b>							
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

\_\_\_\_\_

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22355

Amended Item#10e,19b perFH G773 7/20/99 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert

Cade

2. Date of Death

Month  
JulyDay  
14Year  
1999

3. Time of Death

11:35pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

368 Westberry Drive

4b. City, Town, or Location of Death

Riva

4c. County of Death

Anne Arundel

5. Social Security Number

267-58-5952

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 11, 1941

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Riva

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

368 Westberry Drive

10f. Zip Code

21140

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates 1963-8413. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Program Manager

16b. Kind of Business/Industry

Electronics

17. Father's Name (First, Middle, Last)

Joseph Robert Cade

18. Mother's Name (First, Middle, Maiden Summa)

Rosalee Riley

19a. Informant's Name/Relationship (Type, Print)

Pamela Jean Orr Cade (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

368 Westberry Drive, Riva, MD 21140

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veterans Cem.

Date

07/19

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

Michael P. Kutta

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Primary Amyloidosis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

9 months

one year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael P. Kutta MD

29c. License number

D44161

29d. Date signed (Month, Day, Year)

7-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Bestgate Rd Suite 303 Annapolis MD 21401

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

Bernice S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22356

AMEND #23a PER DR. G773 7-16-99 J.A.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lena Ruth Cole				2. Date of Death Month Day Year July 11, 1999		3. Time of Death 9:30 pm	
	4a. Facility Name (If not institution, give street and number) Abundant Life Assisted Living				4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard	
Funeral Director	5. Social Security Number 280.01.0615		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 2, 1902	
	9. Birthplace (State or Foreign Country) Delaware, OH		10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 9966 Oaklea Court		10f. Zip Code 21042		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) William W. Wilson				18. Mother's Name (First, Middle, Maiden Surname) Alice E. Moore			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Eudora L. Mitchell				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2972 Warrensburg Rd. Delaware, Ohio 43015			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Grove Cemetery		20c. Location - City or Town, State Delaware, Ohio		20d. Date 7/15	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Anthony J. Petro</i>				22. Name and Address of Facility Sterling-Ashton-Schwab F.H. 736 Edmondson Ave. Catonsville, Md. 21228			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Cardiovascular disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i> <i>Primary Degenerative Senescence</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D22856		29d. Date signed (Month, Day, Year) July 13, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jeffrey H. Lewis, 509 11055 Little Patuxent Pkwy, Columbia, Md 21045</i>							
State Registrar	31. Date filed (Month, Day, Year) JUL 16 1999				32. Registrar's Signature <i>[Signature]</i>			





99-4026-510

SHEILIA

CURTIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22357

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sheila Curtis</i>				2. Date of Death Month Day Year <i>JULY 10, 1999</i>		3. Time of Death <i>4:16P.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>2503 VIOLET AVE</i>				4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death	
Funeral Director	5. Social Security Number <i>216-30-7274</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>64</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>12-12-1934</i>		9. Birthplace (State or Foreign Country) <i>MD</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>NA</i>	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10a. Street and Number <i>2503 Violet Avenue</i>			10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>U.S.A</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>NA</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Factory Worker</i>			16b. Kind of Business/Industry <i>Factory</i>	
	17. Father's Name (First, Middle, Last) <i>William Holly</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Callie Knight</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Tia King - Todd Niece</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>308 N. Hilton Street Balto, md</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		Date <i>7-14-99</i>		20c. Location - City or Town, State <i>Catonsville, md</i>	
	21. Signature of Funeral Service Licensee <i>Blondie W...</i>				22. Name and Address of Facility <i>Marchmont West 4300 Wabash Avenue Balto, md 21215</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebral Infarction</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <i>partial</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>O.C.M.E.</i>		29d. Date signed (Month, Day, Year) <i>JULY 11, 1999</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</i>								
State Registrar	31. Date filed (Month, Day, Year) <i>JUL 16 1999</i>		32. Registrar's Signature <i>[Signature]</i>					

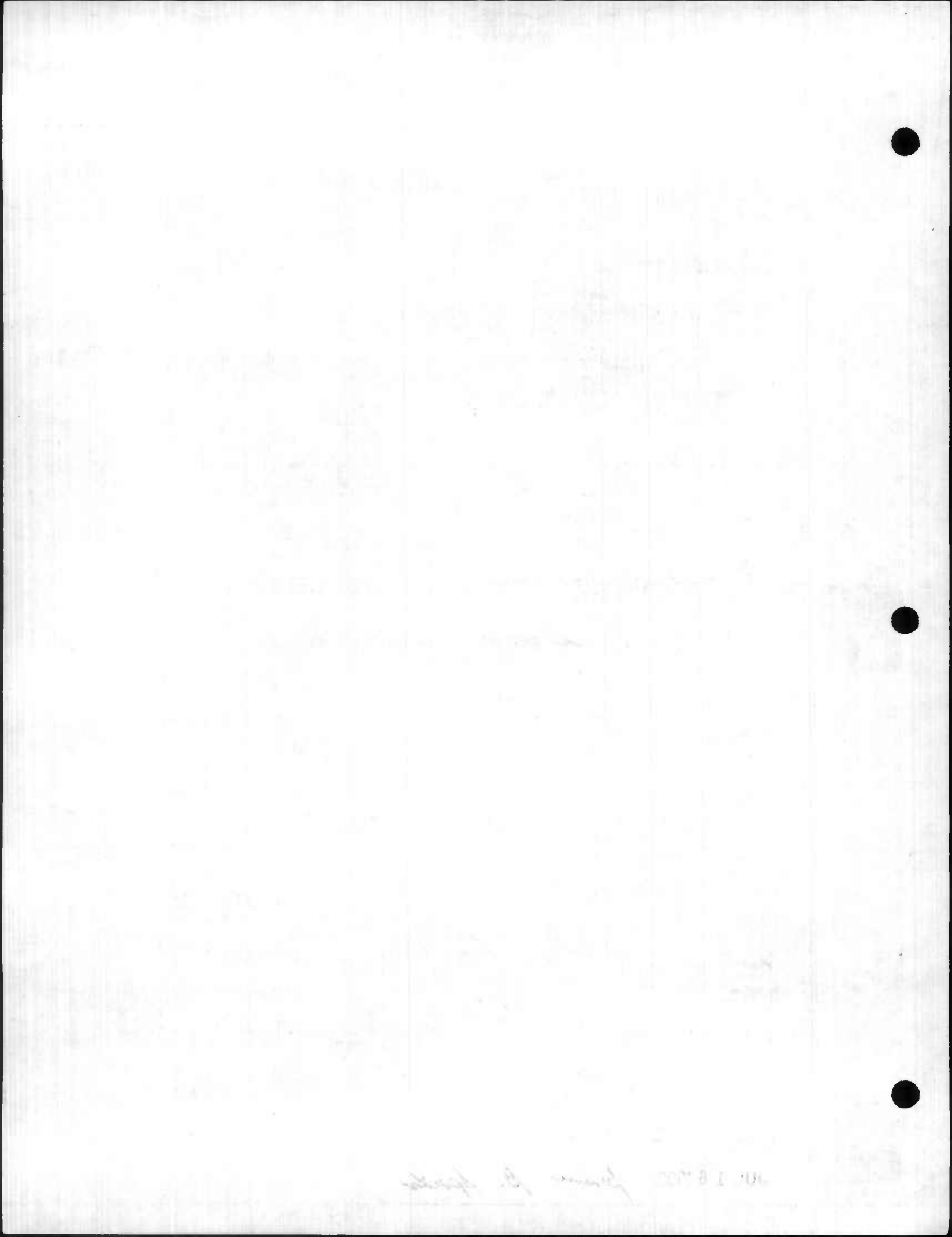
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22358

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Laura Alice Connors</u>				2. Date of Death Month <u>July</u> Day <u>10</u> Year <u>1999</u>				3. Time of Death <u>1725</u>	
	4a. Facility Name (If not institution, give street and number) <u>R. Adams Cowley Shock Trauma</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>180-34-3177</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>55</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Jan 23 1944</u>		9. Birthplace (State or Foreign Country) <u>Pennsylvania</u>	
	Usual Residence of Decedent				10a. State <u>Delaware</u>		10b. County <u>Sussex</u>		10c. City, Town or Location <u>Milton</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <u>420 Chestnut Street</u>				10f. Zip Code <u>19968</u>	
	10g. Citizen of What Country? <u>USA</u>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: _____				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+) <u>0</u>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Home Maker</u>				16b. Kind of Business/Industry <u>Own Home</u>				17. Father's Name (First, Middle, Last) <u>LA Verne Vernon</u>	
	18. Mother's Name (First, Middle, Maiden Surname) <u>Laura Fuller</u>				19a. Informant's Name/Relationship (Type, Print) <u>Robert C. Connors, Jr. (Husband)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>420 Chestnut Street Milton, Delaware 19968</u>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Barratts Chapel Cemetery</u>				20c. Location - City or Town, State <u>Frederica, Delaware</u>	
	21. Signature of Funeral Service Licensee <u>Daniel A. [Signature]</u>				22. Name and Address of Facility <u>McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Maryland 21230</u>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Neurotizing soft tissue infection of sacrum</u>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) <u>July 10 1999</u>				28b. Time of Injury <u>M</u>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>[Signature] MD</u>				29c. License number <u>RES 000</u>	
	29d. Date signed (Month, Day, Year) <u>July 10, 1999</u>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Terrence L. [Signature] MD. R Adams Cowley STC. Univ of MD. Baltimore, MD</u>				31. Date filed (Month, Day, Year) <u>JUL 16 1999</u>	
	32. Registrar's Signature <u>[Signature]</u>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22359

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jonathan Richard Carver

2. Date of Death

Month Day Year  
July 15, 1999

3. Time of Death

6:50 AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-68-0578

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 1, 1954

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1745 Amuskai Road

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1975-1981

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Inspector

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Howard C. Carver

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Phillips

19a. Informant's Name/Relationship (Type, Print)

Mrs. Phyllis Eddy/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1745 Amuskai Road Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet. Cem. 7/20/99 Owings Mills, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Michael P. Pugh*

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *pancreatic cancer*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*4 months*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) *Hospice*

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Dr. Anthony Riley, MD*

29c. License number

*025225*

29d. Date signed (Month, Day, Year)

*July 15, 1999*

30. Name and address of person who completed cause of death item 23e) (Type, Print)

*W. A. Riley, GMC 06701 N. Charles St, Balto, md 21204*

31. Date filed (Month, Day, Year)

*JUL 16 1999*

32. Registrar's Signature

*[Signature]*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020



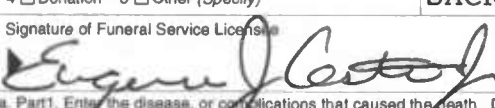
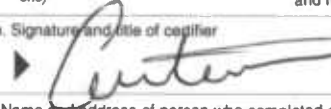
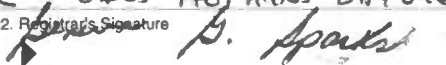
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22360

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MILDRED K. CELANO</b>				2. Date of Death Month <b>JULY</b> Day <b>8</b> Year <b>1999</b>		3. Time of Death <b>6:55 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-26-6433</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8/26/30</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>114 N. KENWOOD AVE.</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>WAITRESS</b>		16b. Kind of Business/Industry <b>CENTRAL CLUB</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>CASIMIR SOKAL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MICHAELINA WIONCZEK</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MR. NICK CELANO</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>114 N. KENWOOD AVE. BALTIMORE, MD.</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SACRED HEART OF MARY</b>		Date <b>7/12/99</b>		20c. Location - City or Town, State <b>DUNDALK, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222</b>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Aortic Rupture</b> Due to (or as a consequence of): b. <b>Cardiac Arrest</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 		29c. License number <b>AJ4147357 - P1992</b>		29d. Date signed (Month, Day, Year) <b>July 08, 1999</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MATTHEW GUETZER Johns Hopkins Bayview Medical Center Balto MD 21224</b>							
	31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature 					

Supplementary

Part of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22361

## Certificate of Death

Reg. No.

ITEM #25

AMENDED ITEM#26 PER VERBAL RESPONSE ME G773 7/14/99 AH

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

BERNICE CANEDY

2. Date of Death

JULY 8 1999

3. Time of Death

3:15pm

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

127-22-5937

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

FEB. 8, 1920

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4101 BATEMAN AVENUE

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

BALTIMORE CITY

17. Father's Name (First, Middle, Last)

FREDERICK CARTER

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA HITCHEN

19a. Informant's Name/Relationship (Type, Print)

JACQUELINE GRIFFIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

928 PRESTWOOD ROAD CATONSVILLE, MD. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

JULY 13

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

NUTTER FUNERAL HOMES, INC.

2501 GWYNNS FALLS PKWY BALTIMORE, MD. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Alzheimer's Disease*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *Coronary artery disease*  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Rhamin Ligon-Munoz

29c. License number

D46089

29d. Date signed (Month, Day, Year)

JULY 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RHAMIN LIGON-MUNOZ 2600 LIBERTY HEIGHTS AVENUE, BALTIMORE

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22362

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Lee Coleman

2. Date of Death

July 13 1999 8:40 PM

3. Time of Death

8:40 PM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-38-7229

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11-11-39

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15 Belhaven Drive

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Thomas Gephardt, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Alverta Merciai

19a. Informant's Name/Relationship (Type, Print)

Harry C. Coleman, Jr. / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Belhaven Drive Balto., Md. 21236

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Balto./Wash. Crematory

Date

07-17-99

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

6415 Belair Rd.  
John C. Miller, Inc. Balto., Md. 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic Encephalopathy

Due to (or as a consequence of):

2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Cancer

Due to (or as a consequence of):

3 Years

c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_  
Due to (or as a consequence of):

\_\_\_\_\_

\_\_\_\_\_

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

*[Signature]* INT MED R2

29c. License number

191874

29d. Date signed (Month, Day, Year)

July 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laura Steel 9000 Franklin Square DRIVE Baltimore, Maryland 21237

31. Date Filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

George B. ... 1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22363

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lionel S. Dorsey</b>				2. Date of Death Month Day Year <b>JULY 8, 1999</b>		3. Time of Death <b>1740 PM</b>						
	4a. Facility Name (If not institution, give street and number) <b>2600 BOONE STREET (WOODED AREA)</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>						
Funeral Director	5. Social Security Number <b>219-66-5077</b> <b>218-32-7145</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>02-28-48</b>	9. Birthplace (State or Foreign Country) <b>MD</b>					
	Usual Residence of Decedent												
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number <b>1214 Walker Avenue Apt. "B"</b>				10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (14 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>		16b. Kind of Business/Industry <b>Bayview Hospital</b>							
17. Father's Name (First, Middle, Last) <b>Lymon King</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Presco</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Louise Dorsey</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21201</b> <b>518 West Preston Street Baltimore, MD.</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		20c. Date <b>07-16-99</b>		20d. Location - City or Town, State <b>Dundalk, MD</b>						
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE NARCOTIC INTOXICATION</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>										
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) <b>Found 7-8-99</b>		28b. Time of Injury <b>Found 5:23 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND IN WOODED AREA</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2600 BLK. BOONE STREET BALTIMORE, MARYLAND</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 9, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>													
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>			32. Registrar's Signature 										

1915

1915

*Handwritten signature*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMSS #10e &amp; 11 PER FH G773 7/16/99 AH

## Certificate of Death

Reg. No. 99 22364

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Wilson Dorsey

2. Date of Death

Month Day Year  
July 12, 1999

3. Time of Death

9:57 a.m.

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

216-22-2757

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
1-2-1928

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State  
Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3010 Fairview Road

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Research Chemist

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Wilson H. Dorsey

18. Mother's Name (First, Middle, Maiden Surname)

Cora Pollard

19a. Informant's Name/Relationship (Type, Print)

Lavinia Dorsey Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3010 Fairview Road Balto, Md 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet

Date

7-19-99

20c. Location - City or Town, State

Owings Mills, Md

21. Signature of Funeral Service Licensee

John Marsh

22. Name and Address of Facility

March F. H. West  
4300 Wabash Avenue Balto, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen Pollock

29c. License number

D19236

29d. Date signed (Month, Day, Year)

July 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Pollock 2401 W. Belvedere Ave., Baltimore, MD 21215-5271

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 22365**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **DAVID ANTHONY DE COSTA** 2. Date of Death Month **JULY** Day **14** Year **1999** 3. Time of Death **18:36**

4a. Facility Name (If not institution, give street and number) **THE JOHNS HOPKINS HOSPITAL** 4b. City, Town, or Location of Death **BALTIMORE, CITY** 4c. County of Death **N/A**

Funeral  
Director

5. Social Security Number **N/A** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **64** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **02/03/1935** 9. Birthplace (State or Foreign Country) **BERMUDA**

Usual Residence of Decedent

10a. State **BERMUDA** 10b. County **N/A** 10c. City, Town or Location **SMITHS PARISH** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **6 TACOMA LANE** 10f. Zip Code **N/A** 10g. Citizen of What Country? **ENGLAND**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **WHITE**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **7YRS** College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **CARPENTER** 16b. Kind of Business/Industry **CARPENTRY**

17. Father's Name (First, Middle, Last) **ANTONIO DE COSTA** 18. Mother's Name (First, Middle, Maiden Surname) **DOROTHY FERREIRA**

19a. Informant's Name/Relationship (Type, Print) **PATRICIA DE COSTA (WIFE)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **6 TACOMA LN. HARRINGTON HUNDREDS, SMITHS PARISH**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **HOLY CALVARY** Date **7/20/99** 20c. Location - City or Town, State **DEVONSHIRE, BERMUDA**

21. Signature of Funeral Service Licensee *William R. Jenkins* 22. Name and Address of Facility **HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. **CORONARY ARTERY DISEASE** Due to (or as a consequence of): **2 YEARS**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **SMOKING HISTORY** 23b. Did tobacco use contribute to the cause of death? ☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☒ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier *Singhal* 29c. License number **RES-000** 29d. Date signed (Month, Day, Year) **July 14th, 1999**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **SUNIL SINGHAL, 600 NORTH WOLFE ST., JOHNS HOPKINS HOSPITAL, BALTIMORE, MD 21287**

31. Date filed (Month, Day, Year) **JUL 16 1999** 32. Registrar's Signature *B. Sparks*

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22366

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Hilda Grace Divel</b>				2. Date of Death Month <b>July</b> Day <b>10, 1999</b>		3. Time of Death <b>1550</b>	
4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>	
5. Social Security Number <b>219-44-3583</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>Sep. 26, 1909</b>	
9. Birthplace (State or Foreign Country) <b>MD</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hancock</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>214B Pennsylvania Ave</b>				10f. Zip Code <b>21750</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Fruit processor</b>		16b. Kind of Business/Industry <b>Agriculture</b>	
17. Father's Name (First, Middle, Last) <b>Martin Luther Peck</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Effland</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Maxine Fleming/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11862 Boyd Road Clear Spring, MD 21722</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Catalpa Cemetery</b>		Date <b>July 13, 1999</b>		20c. Location - City or Town, State <b>Hancock, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Grove Funeral Home, P.A. 141 W. Main Street, Hancock, MD 21750</b>			
23e. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death) <b>a. Acute myocardial Infarction</b>							
Due to (or as a consequence of): <b>b. severe anemia due to GI bleed</b>							
Due to (or as a consequence of): <b>c.</b>							
Due to (or as a consequence of): <b>d.</b>							
Approximate Interval Between Onset and Death <b>hours</b>							
Approximate Interval Between Onset and Death <b>days</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Thomas B. Haywood MD</b>				29c. License number <b>00025714</b>		29d. Date signed (Month, Day, Year) <b>7/11/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas B. Haywood MD 11110 Medical Campus Rd. Hager, MD</b>							
31. Date filed (Month, Day, Year)				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar

July 10, 1954

Mr. J. Edgar Hoover  
U.S. Department of Justice  
Washington, D.C.

Mr. J. Edgar Hoover  
U.S. Department of Justice  
Washington, D.C.

Dear Mr. Hoover:

I am writing you in regard to the matter of the  
U.S. Department of Justice, Washington, D.C.  
I am writing you in regard to the matter of the  
U.S. Department of Justice, Washington, D.C.  
I am writing you in regard to the matter of the  
U.S. Department of Justice, Washington, D.C.

Respectfully,  
[Signature]

Very truly yours,  
[Signature]

44-190-1001

Very truly yours,  
[Signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22367

AMEND ITEM#28a&b PER PHYNS G773 7-16-99 J.A.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH A. JOHNSON EADY</b>						2. Date of Death Month Day Year <b>JULY 9, 1999</b>		3. Time of Death <b>6:45AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>					
Funeral Director	5. Social Security Number <b>227-40-9835</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 24, 1933</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <b>Yes</b> 2 No			
	10e. Street and Number <b>342 Bloom Street</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 Yes 2 No</b> Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>9th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home maker</b>				16b. Kind of Business/Industry <b>Own Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>WILLIE R. WHEAT, SR.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Martin</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>ELEANOR THOMPSON / sister</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1109 Church Street Hopewell, VA 23060</b>					
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>First Baptist Church Cemetery</b>		Date <b>7-14-99</b>		20c. Location - City or Town, State <b>Hopewell, Virginia</b>					
	21. Signature of Funeral Service Licensee <b>[Signature]</b>						22. Name and Address of Facility <b>CHATHAM - HARRIS Funeral Home 5340 REISTERSTOWN ROAD BALTIMORE, Maryland 21208</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory Insufficiency</b> Due to (or as a consequence of): b. <b>Sepsis</b> Due to (or as a consequence of): c. <b>Esophageal Perforation</b> Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death <b>24 hrs</b> <b>2 weeks</b> <b>2 weeks</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Steroid Dependence</b>										23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>	
	24a. Was an autopsy performed? <b>1 Yes 2 No</b>										24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>										26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>7/9/99</b>		28b. Time of Injury <b>6:45AM</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>										29b. Signature and title of certifier <b>[Signature]</b>	
	29c. License number <b>034837</b>										29d. Date signed (Month, Day, Year) <b>7/10/99</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DANIEL P. HARTLEY GBMC</b>										31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>	
	32. Registrar's Signature <b>[Signature]</b>											

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22368

AMEND# 8 PER MD. G777 11-8-99 J.A.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sheah Brieon Freeman

2. Date of Death

Month Day Year  
July 5, 1999

3. Time of Death

18:00

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

NONE

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

1-11-99

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7917 BENT BOUGH ROAD

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

-0-

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

STEVEN L. FREEMAN

18. Mother's Name (First, Middle, Maiden Surname)

WANDA Y. WEEMS

19a. Informant's Name/Relationship (Type, Print)

STEVEN L. FREEMAN (father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7917 BENT BOUGH RD. SEVERN, MARYLAND 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

crownsville veterans

Date

7-9-99

20c. Location - City or Town, State

CROWNSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

Larry Reese

22. Name and Address of Facility

WM. REESE &amp; sons mortuary

821 WEST ST. ANNAPOLIS, MARYLAND 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Hypertension  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

tetralogy of Fallot

Bronchopulmonary Dysplasia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. B. B. B.

29c. License number

D51310

29d. Date signed (Month, Day, Year)

July 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Misbah A. Qureshi, MD 22 S. Greene Street Baltimore, Md. 21201

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

J. B. B.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





99-3987-510

B.K.S

DEBRA FLOYD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22369

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Debra A. Floyd</b>				2. Date of Death Month Day Year <b>JULY 9, 1999</b>		3. Time of Death <b>3:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3230 DILLON STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-64-7890</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT 4, 1952</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>3221 Dillon Street</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (11-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cleaning Lady</b>		16b. Kind of Business/Industry <b>Cleaning Service</b>		17. Father's Name (First, Middle, Last) <b>Joseph Edward Britti</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Korotash</b>		19a. Informant's Name/Relationship (Type, Print) <b>LaQuata Lynn Floyd/daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2070 Larkhall Road Baltimore, MD 21222</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Date <b>7/15/99</b>		20d. Location - City or Town, State <b>Baltimore, MD</b>		21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>	
	22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>J. Pustan, M.D.</b>	
	29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JULY 9, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>	
State Registrar	32. Registrar's Signature <b>B. Sparks</b>		33. Registrar's Title <b>Registrar</b>		34. Registrar's Address <b>111 Penn Street, Baltimore, Maryland 21201</b>		35. Registrar's Phone Number <b>410-333-1111</b>	





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22370

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth M. Fleet

2. Date of Death

Month Day Year  
July 1 1999

3. Time of Death

5:50 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

578-26-2757

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 2, 1914

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

438 Sarah Anne Drive

10f. Zip Code

20711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary/Bookkeeper

16b. Kind of Business/Industry

Florist

17. Father's Name (First, Middle, Last)

Clark Maxwell

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Petrie

19a. Informant's Name/Relationship (Type, Print)

William M. Fleet (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1105 Harbor Way, Churchton, MD 20733

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

07/07

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Thomas H. Hinkley

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Pneumonia

Approximate  
Interval Between  
Onset and Death

1 wk

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHF

Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Gary J. Sprague MD

29c. License number

032036

29d. Date signed (Month, Day, Year)

7/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary J. Sprague 2108 D. Donahue Drive Chesapeake, MD 21619

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

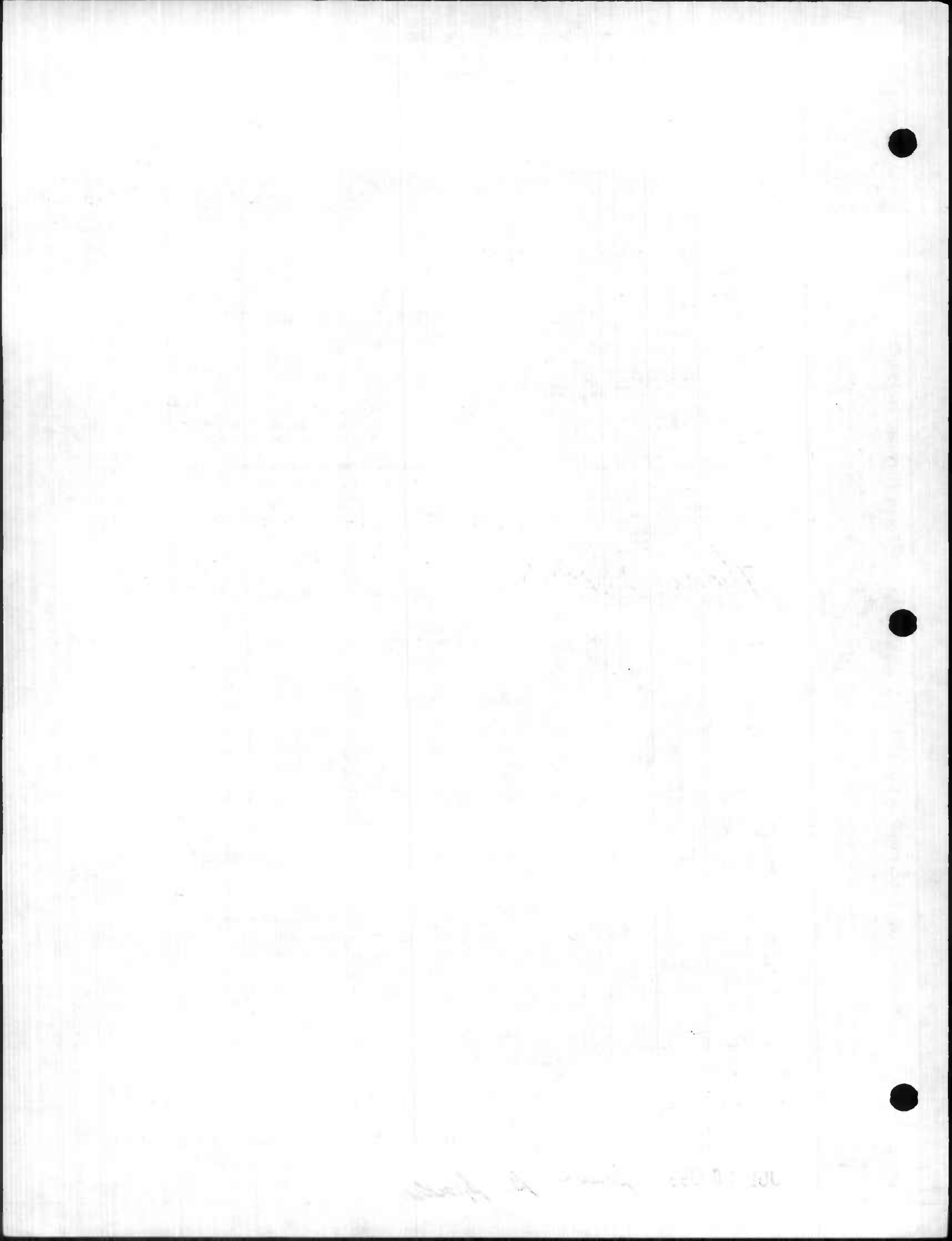
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22371

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charlotte S. Fortenbaugh</b>				2. Date of Death Month <b>July</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>2212</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>171-07-3849</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 9, 1907</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Harwood</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>4187 Solomons Island Road</b>		10f. Zip Code <b>20776</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>				16b. Kind of Business/Industry <b>US Government</b>			
	17. Father's Name (First, Middle, Last) <b>Ira R. Stover</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lottie G. Zeigler</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Robert Miller (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1688 Hemlock Farms, Hawley, PA 18428</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>07/14</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <b>Thomas A. Hardesty</b>				22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Resp Failure</b> <b>b. Severe Aortic Stenosis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> <b>d.</b>				Approximate Interval Between Onset and Death <b>48 hours</b> <b>years</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Steven Resnick MD</b>				
29c. License number <b>DM 35494</b>				29d. Date signed (Month, Day, Year) <b>7/13/99</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Steven Resnick MD</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anne Arundel Medical Center</b>				
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>				32. Registrar's Signature <b>B. Sparks</b>				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 22372

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roger Joseph Gajadhar</b>				2. Date of Death Month Day Year <b>JULY 13, 1999</b>		3. Time of Death <b>9:51 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>City</b>			
Funeral Director	5. Social Security Number <b>215-45-4736</b>	6. Sex <b>150 M 20 F</b>	7. Age (In yrs. last birthday) <b>18</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 9, 1981</b>		9. Birthplace (State or Foreign Country) <b>Trinidad</b>		
	Usual Residence of Decedent									
10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number <b>4219 Star Circle</b>				10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>Trinidad</b>				
11. Marital Status <b>1X Never Married 20 Married</b> 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>			16b. Kind of Business/Industry <b>School</b>			
17. Father's Name (First, Middle, Last) <b>Nandlal Gajadhar</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pamela F. Alexander</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Pamela Alexander (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4219 Star Circle Randallstown, Md 21133</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>All Saints Cemetery</b>		20c. Location - City or Town, State <b>July 17, 1999 Reisterstown, Md</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md 21117</b>						
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Head Injuries</b>						Approximate Interval Between Onset and Death			
	23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Head Injuries</b>						Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? <b>XX</b> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>7/13/99</b>		28b. Time of Injury <b>0245M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Driver of motor vehicle struck pole</b>		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street; McDonough Rd + Planters Mill Rd; Balto, Md</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <b>XX</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 					29c. License number <b>O.C.M.E</b>	
29d. Date signed (Month, Day, Year) <b>JULY 14, 1999</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>						
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100-100000-100000

1

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22373

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Grimes

2. Date of Death

Month  
MAYDay  
27Year  
1999

3. Time of Death

9:06 AM

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

220-60-8399

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 21, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

St. Marys

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

46177 Ellenbee Ct.

10f. Zip Code

20653

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Fernando Grimes

18. Mother's Name (First, Middle, Maiden Summa)

Margarete Wagner

19a. Informant's Name/Relationship (Type, Print)

Brenda Grimes/x-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

46177 Ellenbee Ct. Lexington Park, MD 20653

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ Ronald S. Wade, Director, per DVR

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Coronary arrest

5/25/99

Due to (or as a consequence of):

b.

Severe Diabetic Nephrotic Syndrome

Due to (or as a consequence of):

c.

Poorly controlled Diabetes mellitus

Due to (or as a consequence of):

d.

Epilepsy

weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Antibiotic associated clonidine

⊕ Hep C Antibody ⊕ possible  
cirrhosis  
Alcoholism ⊕ Smoking Hx.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Donald M. Federle MD

29c. License number

D34198

29d. Date signed (Month, Day, Year)

7/14/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

DAVID M. FEDERLE M.D.

PHILIP J. BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

LL

DONALD GRIMES

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the matter of the  
and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.  
I am, Sir, very respectfully,  
Your obedient servant,  
J. H. [Name]

Very truly yours,  
[Signature]  
[Name]  
[Address]  
[City, State]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22374

ITEM#24a.-27&29 PER DR. G773 7-16-99 J.A.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Garmatz</b>				2. Date of Death Month: <b>May</b> Day: <b>15</b> Year: <b>1999</b>		3. Time of Death <b>9:46 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>6825 Campfield Road, #7H</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>212-03-0826</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Nov. 7, 1907</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State: <b>Maryland</b> 10b. County: <b>Baltimore</b> 10c. City, Town or Location: <b>Baltimore</b> 10d. Inside City Limits: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6825 Campfield Road, #7H</b>		10f. Zip Code <b>21208</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>12</b> College (1-4or 5+): <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Executive Secretary</b>		16b. Kind of Business/Industry <b>Federal Government</b>		17. Father's Name (First, Middle, Last) <b>Herman Frederick Garmatz</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Maria Anna Doering</b>		19a. Informant's Name/Relationship (Type, Print) <b>Frank Lapinski/Lawyer</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3410 White Avenue, Baltimore, MD 21214</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>StateAnatomy Board, 655 W. Baltimore Street Baltimore, MD 21201</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Stroke</b> Due to (or as a consequence of): <b>Aneurysm</b> Due to (or as a consequence of): <b>HTSP</b>		Approximate Interval Between Onset and Death		
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Michael S. Wade</b>		29c. License number <b>D31926</b>		29d. Date signed (Month, Day, Year) <b>6/29/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>7141 SECURITY BLVD BALTIMORE, MD 21244</b>		31. Date filed (Month, Day, Year) <b>6/29/99</b>		32. Registrar's Signature <b>Benita B. Sparks</b>		33. Date of Death <b>6/29/99</b>		

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22375

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Irvin Henson</b>				2. Date of Death Month <b>July</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>1:25 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Liberty Medical Center</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-09-9301</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 6, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>4017 Liberty Heights Ave.</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (14 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Baker</b>		16b. Kind of Business/Industry <b>Bakery</b>			
	17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katie Norris</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (daughter) <b>Ms. Michelle Henson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3401 Woodbrook Ave. Balto Md. 21217</b>			
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Thomas Cemetery</b>		20c. Location - City or Town, State <b>7/19/99 Balto. Md.</b>		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. pneumonia</b> Due to (or as a consequence of): <b>b. Chronic obstructive Pulmonary Disease</b> Due to (or as a consequence of): <b>c. Urocephalus</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Renal Insufficiency</b> <b>old cerebrovascular accident</b>				Approximate Interval Between Onset and Death <b>07/08/99</b> <b>unknown</b> <b>07/08/99</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Insufficiency</b> <b>old cerebrovascular accident</b>				23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown			
	24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
	27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>3</b> Suicide <b>6</b> Could not be determined <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Kwang N. Kim MD</b>		29c. License number <b>D17031</b>		29d. Date signed (Month, Day, Year) <b>July 13, 1999</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KWANG N Kim, 2600 Liberty Medical Center, BALTIMORE, MD. 2125</b>							
	31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>B. Sparks</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22376

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Millie Holley				2. Date of Death 7 Nov 99		3. Time of Death 10 A.M.	
	4a. Facility Name (If not institution, give street and number) JOHN HOPKINS BAYVIEW				4b. City, Town, or Location of Death BALTIMORE		4c. Cause of Death N/A	
Funeral Director	5. Social Security Number 218-28645		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 1-7-17	
	9. Birthplace (State or Foreign) S. CAROLINA		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1427 N. ELMWOOD		10f. Zip Code 21213		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clothing Inspector		16b. Kind of Business/Industry Clothing			
	17. Father's Name (First, Middle, Last) John Douglass		18. Mother's Name (First, Middle, Maiden Surname) Edith Brown		19a. Informant's Name/Relationship (Type, Print) Wesley Holley		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4207 N. ELMWOOD	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEDUTUS		20c. Date 7-15-99		20d. Location - City or Town, State HEDUTUS, MD.	
	21. Signature of Funeral Service Licensee Aptha Gorman		22. Name and Address of Facility JOSEPH G. LICKS, JR. HOME 1302 N. CENTRAL AVE. BALTO. MD. 21202					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seizure		Due to (or as a consequence of): Epilepsy		Due to (or as a consequence of): Cardiac Arrhythmia, Sinus Bradycardia		Approximate Interval Between Onset and Death 2 hours 12 years	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {		Due to (or as a consequence of):					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperlipidemia							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Carlton C. Greene		29c. License number D20780		29d. Date signed (Month, Day, Year) 7-12-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLTON C. GREENE, 1717 GAYLOR AVE. BALTIMORE, MD 21209		31. Date filed (Month, Day, Year) JUL 16 1999		32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

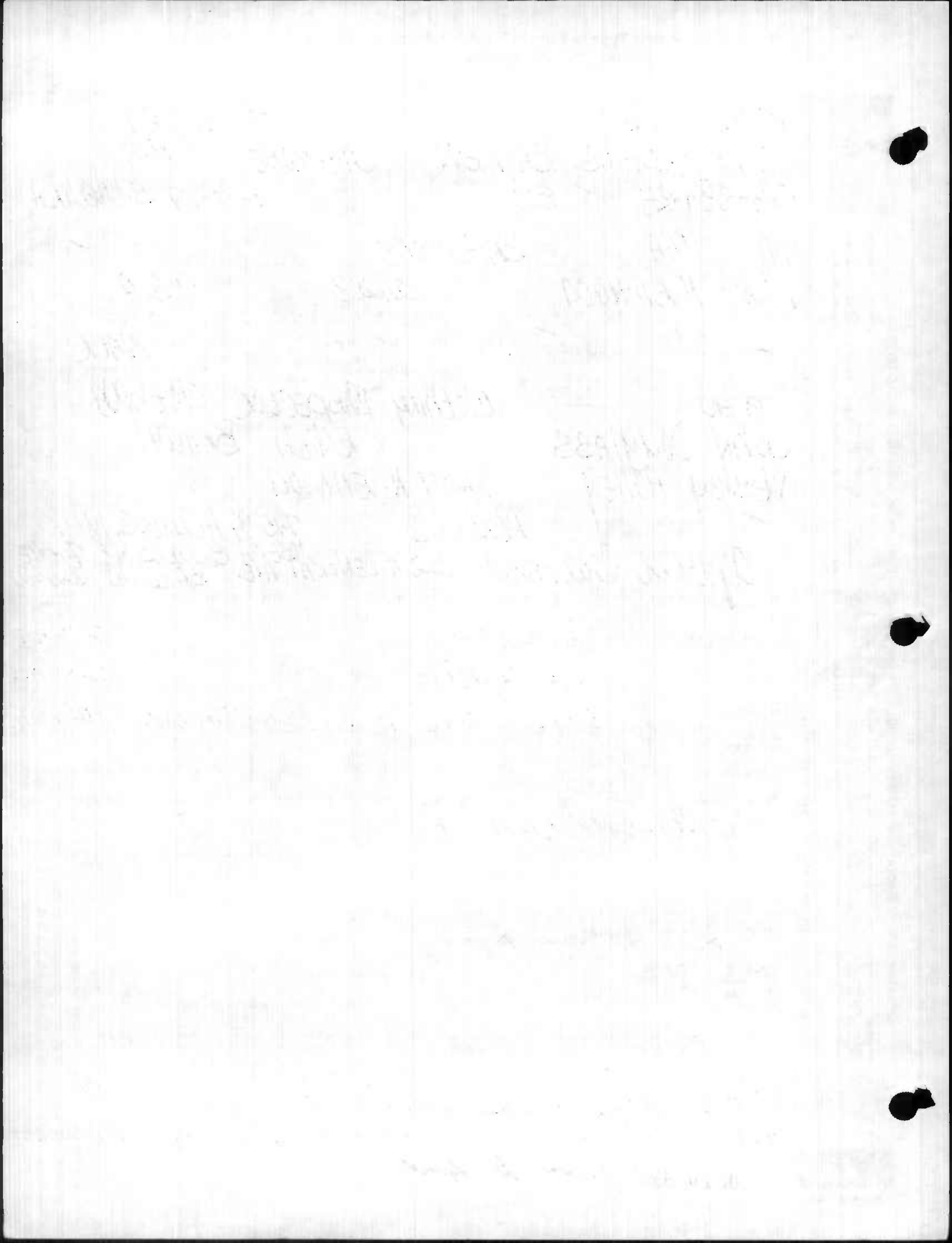
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM#17 PER F.H. G773 7-16-99 J.A. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22377

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLYDE HUSKINS</b>		2. Date of Death Month Day Year <b>JULY 14 1999</b>		3. Time of Death <b>10:25AM</b>
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>249-16-8345A</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>05/17/1920</b>	9. Birthplace (State or Foreign Country) <b>S. Carolina</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10e. State <b>Md</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Linthicum</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>6214 Groveland Road</b>		10f. Zip Code <b>21090</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Insurance</b>
	17. Father's Name (First, Middle, Last) <del>Aurora Huskins</del> <b>DANIEL HUSKINS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Evaleana Williams</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Eveleane Huskins/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6214 Groveland Road, Linthicum, Md 21090</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>7/16 Baltimore, Md</b>
	21. Signature of Funeral Service Licensee <b>Max Marshall</b>		22. Name and Address of Facility <b>Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Ave. Balto, Md 21228</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>CONGESTIVE HEART FAILURE</b> YEARS Due to (or as a consequence of):</p> <p>b. <b>CORONARY ARTERY DISEASE</b> YEARS Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> </div>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>M.D.</b>		29c. License number <b>P: 11950</b>	29d. Date signed (Month, Day, Year) <b>JULY 14 1999</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PIYUSH PATEL, HARBOR HOSPITAL CENTER, MD-21225</b>					
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>Benjamin S. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

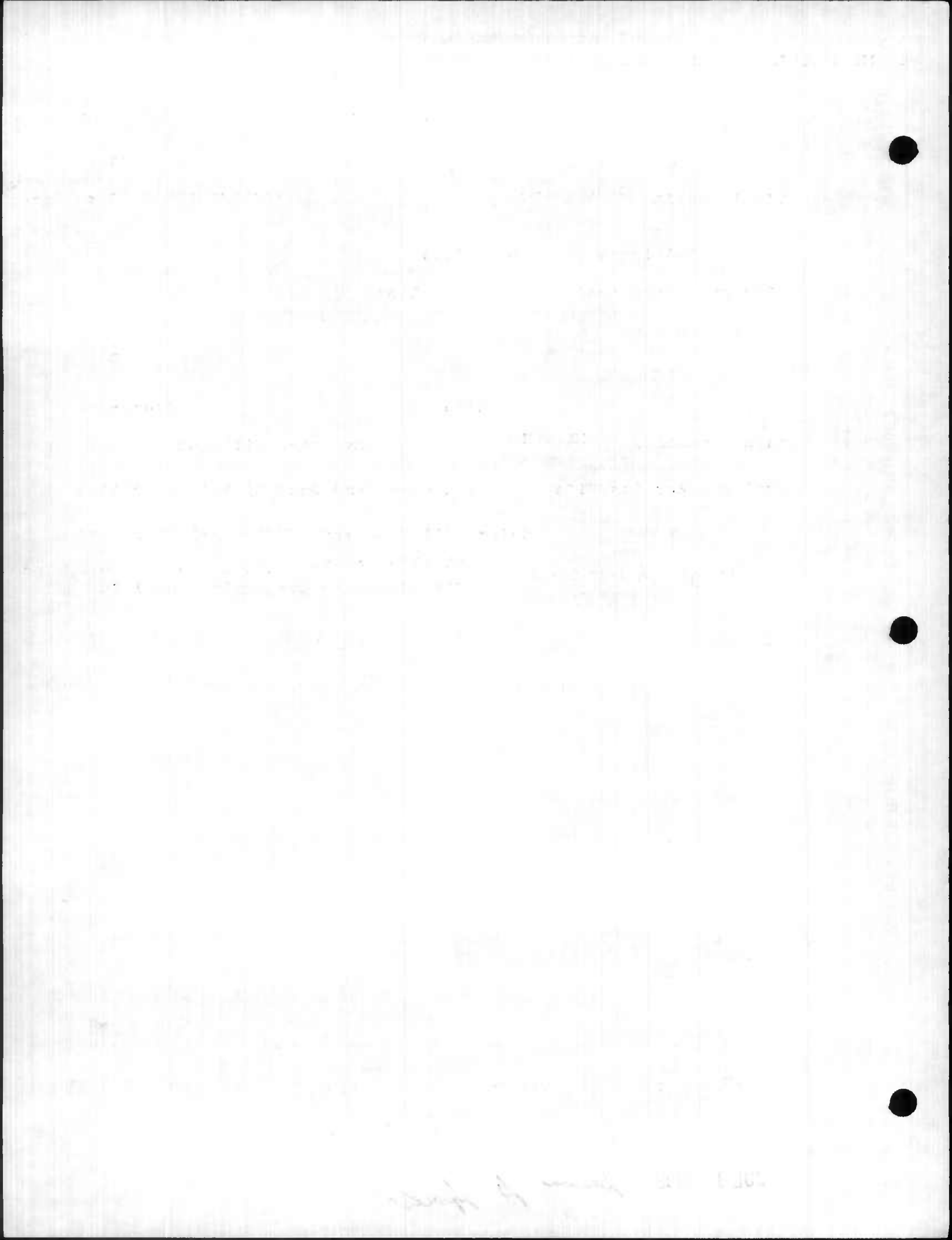
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22378

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Nattie Tolly</i>				2. Date of Death Month Day Year July 08, 99				3. Time of Death 3:00pm	
	4a. Facility Name (If not institution, give street and number) Bluepoint Nursing&Rehab. Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death NA	
Funeral Director	5. Social Security Number 197-09-9824		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 05-25-14		9. Birthplace (State or Foreign Country) SC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 4519 Weitzel Avenue				10f. Zip Code 21214				10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed				16b. Kind of Business/Industry Restaurant	
	17. Father's Name (First, Middle, Last) Irvin Brown				18. Mother's Name (First, Middle, Maiden Sumama) Iola Moore					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Solomon Kohn				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3903 McDonogh Road Randallstown, MD. 21133					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Western Star Cemetery				20c. Location - City or Town, State 07-16-99 Catonsville, MD			
	21. Signature of Funeral Service Licensee <i>Joseph R. Walters</i>				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Ischemic Heart Disease</i> a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Hypertension</i>								Approximate Interval Between Onset and Death <i>Unknown</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was cause related to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD								
29c. License number D 27569		29d. Date signed (Month, Day, Year) 7/13/99								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Allen Hettelman 1838 Greene Tree Rd #300</i>										
31. Date filed (Month, Day, Year) JUL 16 1999		32. Registrar's Signature <i>[Signature]</i>								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22379

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Kennedy</b>		2. Date of Death Month <b>July</b> Day <b>14</b> Year <b>1999</b>		3. Time of Death <b>14:54</b>
	4a. Facility Name (If not institution, give street and number) <b>THE Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>220-18-0969</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>JULY 10, 1927</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Worchester</b>	10c. City, Town or Location <b>Ocean City</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>308 140th Street</b>		10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Owner</b>		16b. Kind of Business/Industry <b>Photography</b>		
	17. Father's Name (First, Middle, Last) <b>Ernest Kennedy</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Elizabeth Baumgardner</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Frances L. Kennedy/wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>308 140th St. Ocean City, MD 21842</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 07/16/99</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>
	21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>		22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		a. <b>Aspiration pneumonia</b> Due to (or as a consequence of):		1 day
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Hepatic failure</b> Due to (or as a consequence of):		3 days
			c. <b>Renal failure</b> Due to (or as a consequence of):		3 days
			d. <b>Hemophilia type A</b> Due to (or as a consequence of):		72 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Human immunodeficiency virus infection</b>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Gregory Clark, M.D.</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>July 14, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Baltimore, MD 21287</b>					
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>					
32. Registrar's Signature <b>Benita S. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

99 22380

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G773

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Brian Keith Kaminski</b>				2. Date of Death Month Day Year <b>JULY 13, 1999</b>		3. Time of Death <b>0851 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>2818 CHESLEY AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-62-7139</b>		6. Sex <b>100 M 200 F</b>		7. Age (In yrs. last birthday) <b>35</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 5, 1963</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1X Yes 20 No</b>		10e. Street and Number <b>2818 Chesley Avenue</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <b>1X Never Married 20 Married</b> <b>30 Widowed 40 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>10 Yes 2X No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>10 Yes 2X No</b> Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry <b>School</b>			
	17. Father's Name (First, Middle, Last) <b>Richard William Kaminski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Dix</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Katherine D. Kaminski - Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2818 Chesley Avenue Baltimore, Maryland 21234</b>			
	20a. Method of Disposition <b>10 Burial 2X Cremation 30 Removal from State</b> <b>40 Donation 50 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>7/19/99</b>		20c. Location - City or Town, State <b>Towson, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Michael E. Canapp</b>				22. Name and Address of Facility <b>LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ETHANOL INTOXICATION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>10 Yes 20 No 30 Probably 40 Unknown</b>	
	24a. Was an autopsy performed? <b>1X Yes 20 No</b>						24b. Were autopsy findings available prior to completion of cause of death? <b>1X Yes 20 No</b>	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1X Yes 20 No</b>		26. Place of Death (Check only one) Hospital: <b>10 Inpatient 20 ER/Outpatient 30 DOA</b> Other: <b>40 Nursing Home 5X Residence 60 Other (Specify)</b>					
	27. Manner of Death <b>10 Natural 20 Accident 30 Suicide 40 Homicide</b> <b>50 Pending investigation 60 Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>Found: 7-13-99</b>		28b. Time of Injury Found: <b>8:35</b>		28c. Injury at Work? <b>10 Yes 2X No</b>	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred <b>UNKNOWN</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND AT HOME</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2818 CHESLEY AVE., BALTO. CITY, MD.</b>	
	29. Certifier (Check only one) <b>10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>J. Pustaner MD</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 14, 1999</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pustaner 111 Penn Street, Baltimore, Maryland 21201</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>				32. Registrar's Signature <b>B. Sparks</b>			



1912

May 10 1912

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State of Maryland / Department of Health and Mental Hygiene

99 22381

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELSIE K MIOTEK</b>				2. Date of Death Month Day Year <b>JULY 14 1999</b>				3. Time of Death <b>11:25 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>CHURCH HOME and Hospital</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>216-03-9052</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7/4/11</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>514 S. DURHAM ST.</b>				10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRINTER / FINISHER</b>				16b. Kind of Business/Industry <b>PRINTING</b>		
17. Father's Name (First, Middle, Last) <b>ANDREW KMIOTEK</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JULIA SAWICKI</b>						
19a. Informant's Name/Relationship (Type, Print) <b>HELEN BOCIANOWSKI</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9405 ARMANDA WAY BALTO. MD 21237</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. STANISLAW CEMET.</b>		20c. Date <b>7/17/99</b>		20d. Location - City or Town, State <b>BALTIMORE, MD</b>		
21. Signature of Funeral Service Licensee <b>Eugene J. Gato</b>				22. Name and Address of Facility <b>KACOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD 21224</b>						
23a. Pertinent, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>CONGESTIVE HEART FAILURE</b> 1 week Due to (or as a consequence of): b. <b>ACUTE MYOCARDIAL INFARCTION</b> 1 week Due to (or as a consequence of): c. <b>ISCHEMIC CARDIOMYOPATHY</b> UNKNOWN Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>05036</b>		29d. Date signed (Month, Day, Year) <b>JULY 14 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>100 N BROADWAY BALTIMORE MD 21231 JULIA T BONACUM MD</b>										
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>				32. Registrar's Signature <b>[Signature]</b>						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland PERMIT TO PHYSICIAN

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerState  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

HAROLD KEENER

AMEND: #23 PART I, 27 PER MEO G774 8-17

Certificate of Death

Reg. No.

99 22382

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Harold L. Keener</b>		2. Date of Death Month Day Year <b>JULY 12, 1999</b>		3. Time of Death <b>1:03 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>902 ST. PAUL STREET #3A</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>216-96-2019</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>30</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>03/01/1969</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>902 St. Paul Street Apartment 3A</b>			10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>		16b. Kind of Business/Industry <b>Factory</b>
17. Father's Name (First, Middle, Last) <b>Charles R. Keener</b>			18. Mother's Name (First, Middle, Maiden Summa) <b>Ruth M. Todd</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Martha McCargish/Aunt</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>713 W. 37th Street Baltimore Maryland 21211</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		Date <b>07/14/99</b>	20c. Location - City or Town, State <b>Baltimore Maryland</b>
21. Signature of Funeral Service Licensee <b>Kathleen Weber CFSP</b>			22. Name and Address of Facility <b>David J. Weber Funeral Homes PA 5311 Edmondson Ave. Baltimore Maryland 21229</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>COMPLICATIONS OF SCHIZOPHRENIA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Monte McHale</b>			29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MS Sparks B. Korse 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22383

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BEULAH LUCKETT				2. Date of Death Month Day Year JULY 11TH 1999		3. Time of Death 01:30 AM		
	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY		
Funeral Director	5. Social Security Number 244-26-8966		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3-20-09	9. Birthplace (State or Foreign Country) N.C.	
	Usual Residence of Decedent								
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1135 MYRTLE AVE.				10f. Zip Code 21201		10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK		16b. Kind of Business/Industry GOVERNMENT			
17. Father's Name (First, Middle, Last) TROY PEACOCK					18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN				
19a. Informant's Name/Relationship (Type, Print) REGINALD LUCKETT (GRAND-SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 ORCHID CT. EDGEWOOD, MARYLAND 21040					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Location - City or Town, State 7-19-99 BALTIMORE, MARYLAND			
21. Signature of Funeral Service Licensee <i>Guillermo Redd</i>				22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>ASPIRATION PNEUMONIA</u> Due to (or as a consequence of):  b. <u>CEREBROVASCULAR ACCIDENT</u> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death HOURS  MONTHS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>M. Vasantha Kumar</i>							
29c. License number D42510		29d. Date signed (Month, Day, Year) July 11th 1999							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M. VASANTHA KUMAR MD, 821 N. EUTAW ST # 407 MD 21201									
31. Date filed (Month, Day, Year) JUL 16 1999		32. Registrar's Signature <i>B. Sparks</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22384

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Lacey				2. Date of Death Month Day Year JULY 12, 1999				3. Time of Death 9:00pm	
	4a. Facility Name (If not institution, give street and number) Homewood at Williamsport				4b. City, Town, or Location of Death Williamsport				4c. County of Death Washington	
Funeral Director	5. Social Security Number 215-03-3490		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 7, 1903		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 6110 C Edmondson Avenue				10f. Zip Code 21228		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CPA			16b. Kind of Business/Industry Chemical Company			
	17. Father's Name (First, Middle, Last) Benjamin F. Henson				18. Mother's Name (First, Middle, Maiden Surname) Nancy B. Rutherford					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Donna Jean Spigler/niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Guilford Ave. Hagerstown, MD 21740					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Mausoleum		Date 7/14/99		20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensee Dawn F. McDonald				22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Baltimore, MD 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic cardiovascular disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Possible level of infection, viral failure</u> <u>Not of pneumonia</u> <u>anemia, dehydration</u>									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier [Signature]				29c. License number D26806		29d. Date signed (Month, Day, Year) 7/13/99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) And. Howard 747 Northland Hagerstown MD 21742									
31. Date filed (Month, Day, Year) JUL 16 1999										
32. Registrar's Signature [Signature]										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22385

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George Lowry</b>				2. Date of Death Month <b>July</b> Day <b>09</b> Year <b>1999</b>				3. Time of Death <b>1:30 P.M.</b>						
	4a. Facility Name (If not institution, give street and number) <b>1519 Church Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>246-24-1183</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 27, 1924</b>		9. Birthplace (State or Foreign Country) <b>NC</b>						
	Usual Residence of Decedent														
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number <b>1519 Church Street</b>				10f. Zip Code <b>21226</b>				10g. Citizen of What Country? <b>United States</b>							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>American Indian</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Drywall Finisher</b>				16b. Kind of Business/Industry <b>Home Improvement</b>							
17. Father's Name (First, Middle, Last) <b>Daniel Lowry</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosie Lee Maynor</b>											
19a. Informant's Name/Relationship (Type, Print) <b>Delton Lowry / Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>807 Whistling Rufus Road, Pembroke NC 28372</b>											
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Prospect Med. Hol. Church</b>			Date <b>Jul. 13, 1999</b>		20c. Location - City or Town, State <b>Pembroke, NC</b>							
21. Signature of Funeral Service Licensee <b>Victor P. Doda, Jr.</b>				22. Name and Address of Facility <b>Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue Baltimore Maryland 21230</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypertensive Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus + Heat Exposure</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <b>Capital</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) <b>Found 7/11/99</b>		28b. Time of Injury <b>1:30 pm</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject exposed to environmental heat</b>						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>dwelling</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1519 Church Street Baltimore Maryland</b>												
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <b>THEODORE M. KIRBY</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>July 10, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KIRBY</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>															
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>			32. Registrar's Signature <b>B. Sparks</b>												

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.  
Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22386

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sara

Long

2. Date of Death

Month Day Year  
July 14, 1999

3. Time of Death

10:06AM

4a. Facility Name (If not institution, give street and number)

3 Torlina Ct., Apt. D,

4b. City, Town, or Location of Death

Woodlawn

4c. County of Death

Funeral  
Director

5. Social Security Number

188-22-2536

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 10, 1928

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3 Torlina Court Apt D

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Morgan Watkins

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Bender

19a. Informant's Name/Relationship (Type, Print)

Holly Teal (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Cherrydell Road, Catonsville, MD 21228

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore National Cem.

Date

7/19/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.  
1630 Edmondson Ave., Catonsville, Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Diabetes mellitus  
Due to (or as a consequence of):

DX '94

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

mediastinal neurogenic tumor

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending☐ Investigation☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Boersma MD

29c. License number

D 40048

29d. Date signed (Month, Day, Year)

7-14-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D. BOERSMA MD 4660 Wilkens Ave #100 Balt MD 21229

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#4c,10b perPhy G773 7/16/99 EW

## Certificate of Death

Reg. No.

99 22387

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Hayes Laatsch</b>				2. Date of Death Month <b>07</b> Day <b>11</b> Year <b>99</b>		3. Time of Death <b>0719 Hrs.</b>	
	4a. Facility Name (If not institution, give street and number) <b>12100 SWAIN RD, NE</b>				4b. City, Town, or Location of Death <b>LITTLE ORLEANS, MD</b>		4c. County of Death <b>Washington</b> Alleganey	
Funeral Director	5. Social Security Number <b>481-10-9191</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b>		8. Date of Birth (Month, Day, Year) <b>Sep 6, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>Missouri</b>		10a. State <b>MD</b>		10b. County <b>Alleganey</b>		10c. City, Town or Location <b>Little Orleans</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12100 Swain Rd. N.E.</b>		10f. Zip Code <b>21766</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>		16b. Kind of Business/Industry <b>Education</b>				
17. Father's Name (First, Middle, Last) <b>John Adams Wollenman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Elizabeth O'Malley</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Twentey/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12100 Swain Rd. N.E. Little Orleans, MD 21766</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Memorial Park Cemetery</b>		Date <b>Jul 17, 1999</b>		20c. Location - City or Town, State <b>Columbia, MO</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Grove Funeral Home, P.A.</b> <b>141 W. Main St., Hancock, MD 21750</b>						
23a. Immediate Cause (Final disease or condition resulting in death) <b>Hypoxia</b>		23b. Due to (or as a consequence of): <b>Pericardial + Atrial Effusions</b>		23c. Due to (or as a consequence of): <b>Metastatic Pancreatic Cancer</b>		23d. Due to (or as a consequence of):		
23e. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Mark S. Baron, M.D.</b>		29c. License number <b>D0053071</b>		29d. Date signed (Month, Day, Year) <b>07/11/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARK S. BARON, M.D. 11110 Medical Campus Rd Ste 226 Hagerstown, MD</b>								
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #23a PER MD G773 7/14/99 AH

## Certificate of Death

Reg. No.

99 22388

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN MONAHAN LONG

2. Date of Death

JULY 3, 1999

3. Time of Death

11:00 AM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

217 24 5139

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov. 30, 1912

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

317 W. Riverview Road

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To Be Completed by Registrar

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Lord Baltimore Hotel

17. Father's Name (First, Middle, Last)

William Fitzpatrick

18. Mother's Name (First, Middle, Maiden Summa)

Elizabeth Abrams

19a. Informant's Name/Relationship (Type, Print)

Doris Auld / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

317 W. Riverview Road Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Memorial Park 7/6/99

Date

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Doris Auld

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE HYPERKALEMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year 4 days

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RENAL FAILURE

Due to (or as a consequence of):

1 year

c. ATHEROSCLEROSIS

Due to (or as a consequence of):

7 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul J. Liveness MD

29c. License number

D23774

29d. Date signed (Month, Day, Year)

JULY 4 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL T. LIVENGOOD MD 912 SETON DR CUMBERLAND MD 21502

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 1999

32. Registrar's Signature

Paul J. Liveness

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

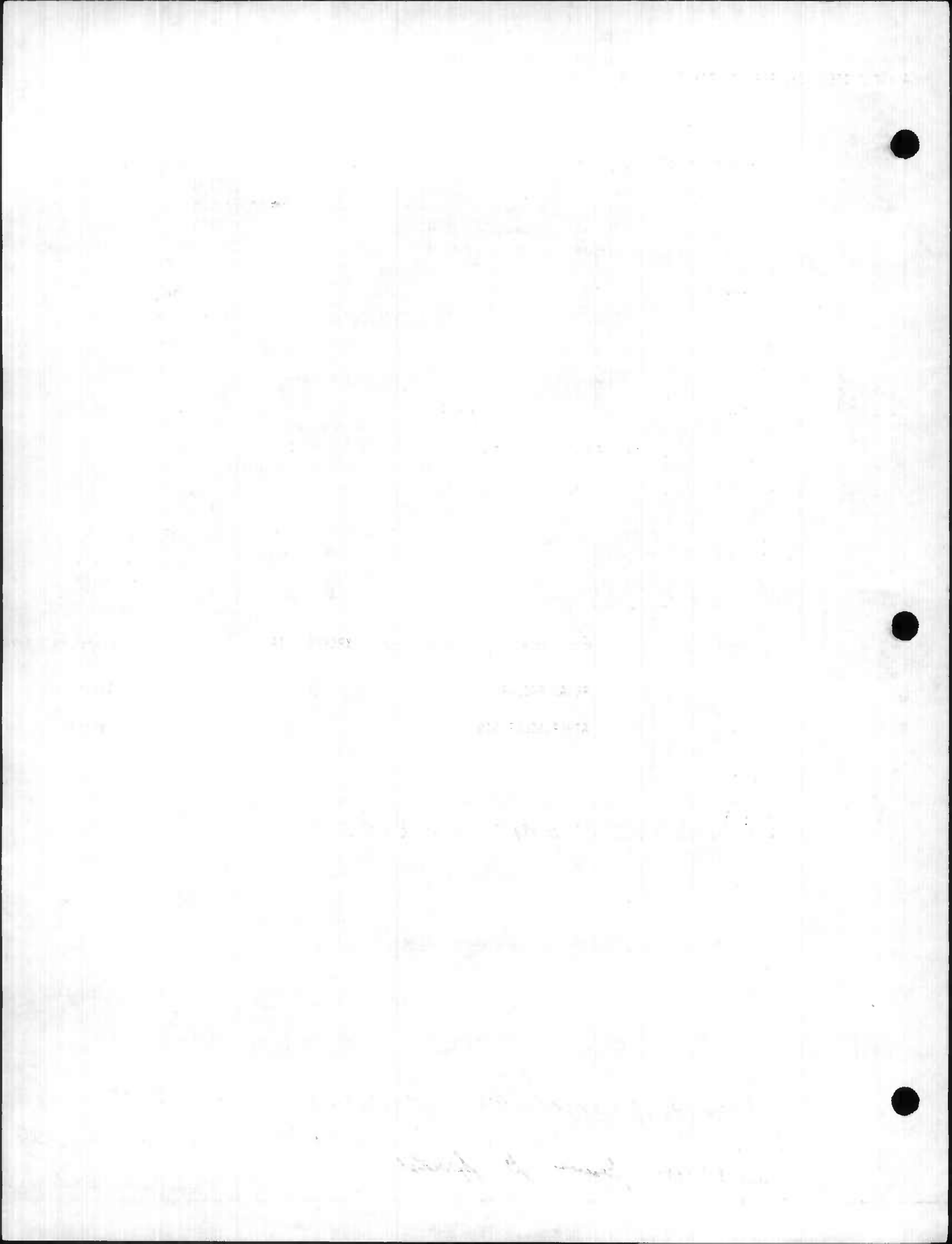
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22389

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Herbert Frazier Murray</u>				2. Date of Death Month <u>July</u> Day <u>12</u> Year <u>1999</u>		3. Time of Death <u>5:00 P.M.</u>	
	4a. Facility Name (If not institution, give street and number) <u>Church Home and Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>028-14-2974</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <u>75</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>DEC 29, 1923</u>	
	9. Birthplace (State or Foreign Country) <u>Massachusetts</u>		10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <u>204 Wyndhurst Avenue</u>			
	10f. Zip Code <u>21210</u>				10g. Citizen of What Country? <u>USA</u>			
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>WWII</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5+</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Judge</u>		16b. Kind of Business/Industry <u>U.S. District Court</u>	
	17. Father's Name (First, Middle, Last) <u>Arnold H. Murray</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Hilda Frazier</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>Jane Ward Murray/Wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>204 Wyndhurst Avenue Baltimore, MD 21210</u>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory, Inc.</u>		20c. Location - City or Town, State <u>7/15/99 Baltimore, MD</u>	
	21. Signature of Funeral Service Licentiate <u>Edward A. Gorchik</u>				22. Name and Address of Facility, Cremation Society of MD, Inc. <u>299 Frederick Road Baltimore, MD 21228</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <u>Aspiration Pneumonia</u> Due to (or as a consequence of):  b. <u>Parkinson's disease</u> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death <u>Days</u> <u>Years</u>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Registrar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>[Signature]</u>				
29c. License number <u>140525</u>				29d. Date signed (Month, Day, Year) <u>July 12, 1999</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Robert Titani, m.m. Church Hospital</u>				31. Date filed (Month, Day, Year) <u>JUL 16 1999</u>				
32. Registrar's Signature <u>[Signature]</u>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, R

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22390

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Elizabeth Mears</b>				2. Date of Death Month Day Year <b>JULY 14, 1999</b>		3. Time of Death <b>7:53 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>5731 FOXHALL FARM ROAD</b>				4b. City, Town, or Location of Death <b>CATONSVILLE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>075-16-8407</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUL 27, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5731 Foxhall Farm Road</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Nelson B. Keeler</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Beaney</b>		19a. Informant's Name/Relationship (Type, Print) <b>Susan Whiteford/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>806 Robin Hood Hill Sherwood Forest, MD 21405</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Date <b>7/16/99</b>		20d. Location - City or Town, State <b>Baltimore, MD</b>		21. Signature of Funeral Service Licensee <b>Edward A. Gregorchik</b>		
22. Name and Address of Facility <b>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. Intra-oral gunshot wound</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <b>Limited</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year) <b>7-14-99</b>		28b. Time of Injury <b>unknown</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot self</b>		
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Residence</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>5731 Foxhall Farm Baltimore County, Maryland</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Atty A. Mackay, MD</b>		
29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JULY 15, 1999</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		
32. Registrar's Signature <b>James B. Sparks</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





99-3874-510

B.K.S

JAMES MELVIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 22391

AMEND: #23 PART I, 27, 28A-F PER MEO G773 7-22-99 WR.

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Clifton Melvin</b>				2. Date of Death Month Day Year <b>JULY 6, 1999</b>				3. Time of Death <b>0408 AM</b>														
	4a. Facility Name (If not institution, give street and number) <b>723 EAST BIDDLE STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>														
Funeral Director	5. Social Security Number <b>218-58-4524</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAR 25, 1953</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>														
	Usual Residence of Decedent																						
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No															
10e. Street and Number <b>Unk.</b>				10f. Zip Code <b>Unk.</b>				10g. Citizen of What Country? <b>USA</b>															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>															
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>Beverage Company</b>															
17. Father's Name (First, Middle, Last) <b>Redell Melvin, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Mae Blue</b>																			
19a. Informant's Name/Relationship (Type, Print) <b>Derrick Williams/son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3515 Chesterfield Ave. Baltimore, MD 21213</b>																			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 7/14/99</b>				20c. Location - City or Town, State <b>Baltimore, MD</b>															
21. Signature of Funeral Service Licensee <b>Edward A. Gregorich</b>				22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>																			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>NARCOTIC INTOXICATION</b></td> <td rowspan="4">           Due to (or as a consequence of):         </td> <td></td> </tr> <tr> <td>b.</td> <td></td> <td></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>NARCOTIC INTOXICATION</b>	Due to (or as a consequence of):		b.			c.			d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>NARCOTIC INTOXICATION</b>	Due to (or as a consequence of):																				
	b.																						
	c.																						
	d.																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																							
26. Place of Death (Check only one) Hospice: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>FOUNDED 7-6-99</b>		28b. Time of Injury <b>4:00 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>															
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: RESIDENCE</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>723 E. BIDDLE STREET BALTIMORE, MARYLAND</b>																	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																							
29b. Signature and title of certifier <b>Wayne A. Yelle MD</b>				29c. License number <b>O.C.M.E</b>				29d. Date signed (Month, Day, Year) <b>JULY 6, 1999</b>															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Wayne A. Yelle 111 Penn Street, Baltimore, Maryland 21201</b>																							
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>B. Sparks</b>																					

CHINESE LITERATURE

1748

Chinese Literature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22392

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith E. Madsen				2. Date of Death Month Day Year July 08, 1999		3. Time of Death 9:59 A.M.		
	4a. Facility Name (If not institution, give street and number) 3 North Linwood Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 270-22-6613		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 03/11/1917		
	9. Birthplace (State or Foreign Country) Canada		10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3 N. Linwood Avenue		10f. Zip Code 21224		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Upholstry		17. Father's Name (First, Middle, Last) Unknown		18. Mother's Name (First, Middle, Maiden Surname) Unknown	
19a. Informant's Name/Relationship (Type, Print) James Griffin/Friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 N. Linwood Avenue		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington		20c. Location - City or Town, State Laurel	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Moran-Ashton Dabrowski Funeral Home, Inc 3000 E. Baltimore Street, Balto 21224		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? Inspection 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 09, 1999		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 16 1999		32. Registrar's Signature 		33. State Registrar JUL 16 1999			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND: ITEM: #1 PER MD G773

State of Maryland / Department of Health and Mental Hygiene

Amended Items#4a-c,26 perPhyG773 7/16/99 EW

Certificate of Death

Reg. No.

99 22393

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <u>Lingard GRANT meise</u>				2. Date of Death Month <u>June</u> Day <u>15</u> Year <u>1999</u>		3. Time of Death <u>10:15a.m.</u>	
4a. Facility Name (If not institution, give street and number) <u>Good Samaritan Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore Co</u>		4c. County of Death <u>Baltimore</u>	
5. Social Security Number <u>217-01-4183</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <u>85</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>March 6, 1914</u>	
9. Birthplace (State or Foreign Country) <u>Baltimore Co., MD</u>							
10a. State <u>Maryland</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Baltimore County</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>135 Sipple Avenue</u>				10f. Zip Code <u>21236</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u>		College (1-4 or 5+) <u>N/A</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>House Painter</u>		16b. Kind of Business/Industry <u>Guzzo Painters</u>	
17. Father's Name (First, Middle, Last) <u>William Meise</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Theresa Manner</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Betty Jean Deetz (Daughter)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>117 Leslie Avenue Baltimore, Maryland 21236</u>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Parkwood Cemetery</u>		Date <u>6/18/99</u>		20c. Location - City or Town, State <u>Baltimore, Maryland</u>	
21. Signature of Funeral Service Licensee <u>Donna Glessner Chojnicki</u>				22. Name and Address of Facility <u>Lassahn Funeral Home, Inc.</u> <u>7401 Belair Road, Baltimore, Maryland 21236-4625</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. metastatic colon cancer</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <u>1 mo.</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>Daughter's Residence</u>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>D34014</u>		29d. Date signed (Month, Day, Year) <u>6-24-99</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Stacy Lynn Pender #412 Baltimore 21235</u>							
31. Date filed (Month, Day, Year) <u>JUL 16 1999</u>				32. Registrar's Signature <u>[Signature]</u>			

State Registrar





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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23 PART I, PER MD G773 7-16-99 WR.

Certificate of Death

Reg. No.

99 22394

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY N. MINKIN</b>				2. Date of Death Month Day Year <b>JUNE 28, 1999</b>		3. Time of Death <b>1:10 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CHERRYWOOD MANOR NURSING HOME</b>				4b. City, Town, or Location of Death <b>REISTERSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>162-03-6235</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 10, 1905</b>	
	9. Birthplace (State or Foreign Country) <b>RUSSIA</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>3 LYDIA COURT</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESMAN</b>		16b. Kind of Business/Industry <b>AUTOMOBILES</b>			
	17. Father's Name (First, Middle, Last) <b>WOLFE MINKIN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH POZNANSKY</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>DR. SANFORD MINKIN / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 BARNSTABLE COURT - OWINGS MILLS, MD 21117</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ANSHE EMUNAH AITZ CHAIM</b>		20c. Date <b>6/30/99</b>		20d. Location - City or Town, State <b>BALTIMORE, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Renal Failure</b> Due to (or as a consequence of): b. <b>Senescence</b> Due to (or as a consequence of): c. <b>DEMENTIA</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier  M.D.				29c. License number <b>D50557-maryland</b>		29d. Date signed (Month, Day, Year) <b>6/28/99</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mini Panikar, M.D., 250 Main St, Reisterstown, MD 21136</b>							
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature 						

Division of Vital Records, P.O. Box 68760,

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22395

AMENDED ITEM #13 PER FH G773 7/16/99 AH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bethel Jennie Mines</b>				2. Date of Death Month <b>July</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>02:11 PM.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>146-44-5518</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>53 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>May 26, 1946</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
10e. Street and Number <b>133 N. Duncan</b>				10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (14 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>			
17. Father's Name (First, Middle, Last) <b>Unknown Gardiner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Creola Slate/Mother-in-Law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>125 N. Duncan St. Baltimore, Maryland 21231</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial</b>		Date <b>7/17/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <i>David J. Weber</i>				22. Name and Address of Facility <b>David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) <b>7-12-99</b>		28b. Time of Injury <b>1:35 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred <b>Person Struck by Truck</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1005K U.S. Highway - NE K. D. Williams</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>Maureen Bone Chale</i>			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>July 13, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M.D. Spinks P. Kosh and 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>			32. Registrar's Signature <i>B. Spinks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

AHS



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22396

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AGNES MACALUSO

2. Date of Death

July 12 1999

3. Time of Death

1835

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

212-03-7321

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 25, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3004 North Ridge Road

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

James C. Hynes

18. Mother's Name (First, Middle, Maiden Surname)

Clara C. Yienger

19a. Informant's Name/Relationship (Type, Print)

James V. Macaluso/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10207 Greenside Dr. Cockeysville, Maryland 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

New Cathedral Cemetery

Date

7/15/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

David J. Weber Funeral Homes, P.A.  
5311 Edmondson Ave. Baltimore, Maryland 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. recent myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. atherosclerotic cardiovascular disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D34385

29d. Date signed (Month, Day, Year)

July 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G.S. Groman, 11085 Little Patuxent Parkway, Columbia, MD 21044

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22397

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY HELEN MACK</b>				2. Date of Death Month <b>JULY</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>11:50 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>945 ROSEDALE AVENUE</b>				4b. City, Town, or Location of Death <b>ROSEDALE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212469092</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>53</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JULY 5, 1946</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>ROSEDALE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>945 ROSEDALE AVENUE</b>		10f. Zip Code <b>21237</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HAIRDRESSER</b>				16b. Kind of Business/Industry <b>HAIRDRESSING</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>STEPHEN MILWICZ</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARIE MAHON</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>GEORGE D. MACK / HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>945 Rosedale Ave Rosedale, MD 21237</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD</b>		20c. Location - City or Town, State <b>7/16/99 BALTIMORE, MD</b>	
	21. Signature of Funeral Service Licentiate <i>Denise S. Kelly</i>				22. Name and Address of Facility <b>CVACH/ROSEDALE FUNERAL HOME</b> <b>1211 CHESACO AVENUE BALTO, MD 21237</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>BOWEL OBSTRUCTION</b> <b>RECTAL CARCINOMA</b>				Approximate Interval Between Onset and Death <b>1 month</b> <b>18 mos.</b>			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>PULMONARY METASTASES</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how Injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>J. C. Downs, M.D.</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D33624</b>				29d. Date signed (Month, Day, Year) <b>7/13/99</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN C DOWNS</b>				31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>John C. Downs</i>				33. State Registrar <b>JUL 16 1999</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ALH 10





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22398

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA NAGEL

2. Date of Death

Month Day Year  
July 14 1999

3. Time of Death

3:42 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

214166033

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

8. Date of Birth

Month Day Year  
AUG 22 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1113 MITCHELL ST.

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNK

College (1-4 or 5+)

UNK

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PRINTING

16b. Kind of Business/Industry

BANK STATIONARY

17. Father's Name (First, Middle, Last)

WILLIAM S. CHURCH

18. Mother's Name (First, Middle, Maiden Surname)

SOPHIE BROWN

19a. Informant's Name/Relationship (Type, Print)

PHYLLIS WARD / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1113 MITCHELL STREET ANNAPOLIS, MD 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH

Date

7/19/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME  
1211 CHESACO AVENUE BALTO, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

196659

29d. Date signed (Month, Day, Year)

7-14-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ram Rao Peddada 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

State Registrar

Nagel, Virginia Elizabeth  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

AH 6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22399

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL J. ROONEY

2. Date of Death

Month Day Year  
JULY 13, 1999

3. Time of Death

12:30 P.M.

4a. Facility Name (If not institution, give street and number)

CHESAPEAKE HOSPICE HOUSE

4b. City, Town, or Location of Death

LINTHICUM

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

214.26.1999

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10/17/32

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1300 GILBERT PLACE

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INSTALLER

16b. Kind of Business/Industry

ADT

17. Father's Name (First, Middle, Last)

PAUL ROONEY

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE HUGHES

19a. Informant's Name/Relationship (Type, Print)

PATSY M. ROONEY - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1300 GILBERT PLACE, GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEM. PARK

Date

7/16

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Informant/Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, PA

426 CRAIN HWY., SW., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Mesothelioma metastatic to bone

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice House

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

027938

29d. Date signed (Month, Day, Year)

7/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. [Signature] 795 Aqueduct Rd. Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22400

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Rowan

2. Date of Death

July 14, 1999

3. Time of Death

10:00 PM

4a. Facility Name (If not institution, give street and number)

Future Care Cherrywood

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

128-18-0884

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 24, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Hampstead

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4148 Double Tree Lane

10f. Zip Code

21074

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Management

16b. Kind of Business/Industry

AT&T

17. Father's Name (First, Middle, Last)

Francis Rowan

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Gallagher

19a. Informant's Name/Relationship (Type, Print)

Vincent Rowan (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4148 Double Tree Lane, Hampstead, MD 21074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

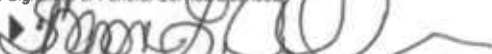
20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park

Date

7/17/99 Woodlawn, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Witzke Funeral Homes, Inc.  
1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA - ALZHEIMER'S TYPE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

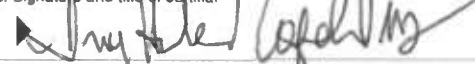
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D27034

29d. Date signed (Month, Day, Year)

July 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. H. H. Copeland MD 5310 Old Court Road Randallstown MD 21133

31. Date filed (Month, Day, Year)

JUL 16 1999

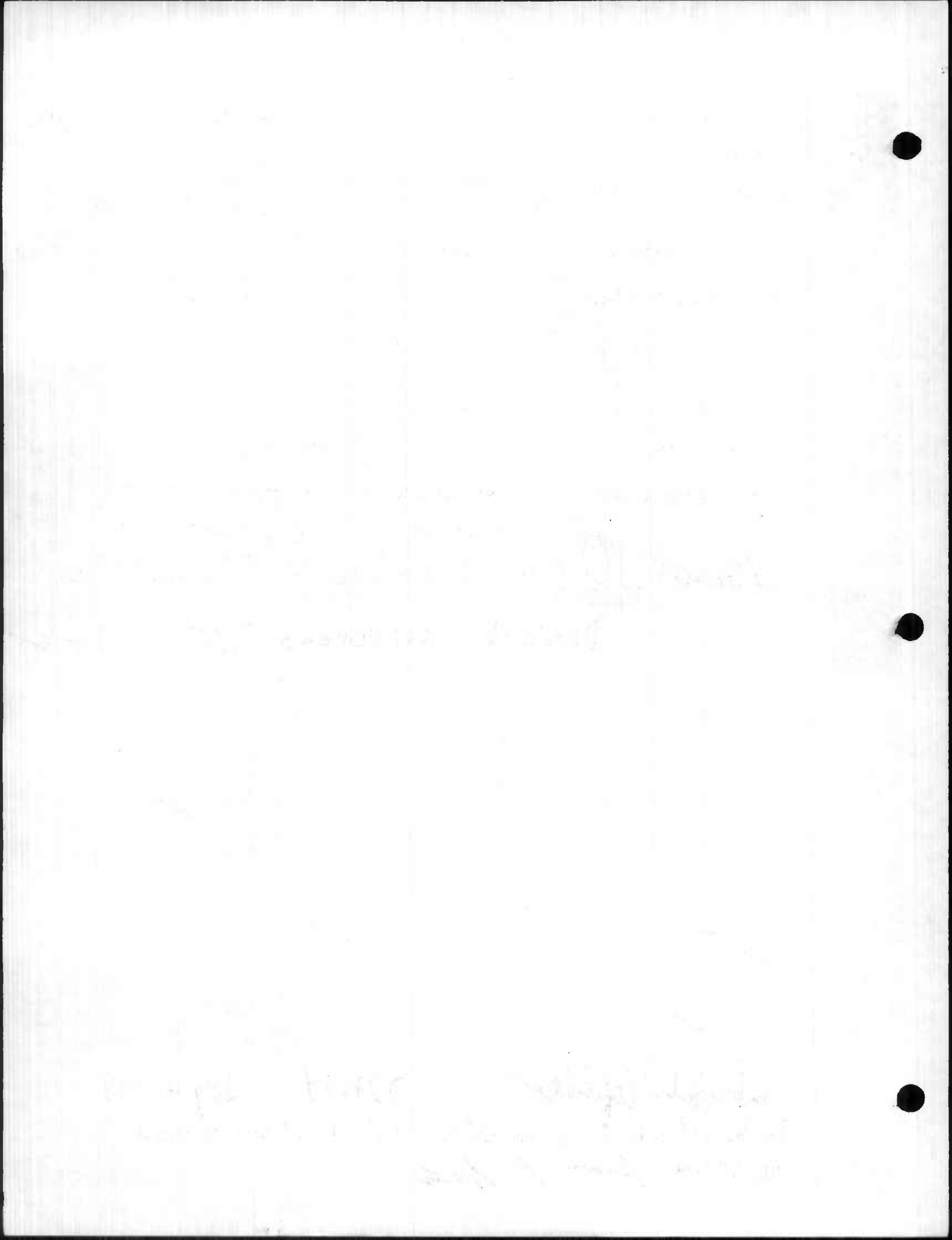
32. Registrar's Signature



State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22401

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernard Smith</b>				2. Date of Death Month Day Year <b>July 16 1999</b>			3. Time of Death <b>6-30 AM</b>																								
	4a. Facility Name (If not institution, give street and number) <b>Liberty Medical center</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>N/A</b>																								
Funeral Director	5. Social Security Number <b>213-30-7080</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>65 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>10-23-33</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>																							
	Usual Residence of Decedent																															
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <b>1 X Yes 2 No</b>																								
10e. Street and Number <b>1501 N. DUKELAND</b>				10f. Zip Code <b>21216</b>			10g. Citizen of What Country? <b>USA</b>																									
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 Yes 2 No</b>			14. Race - American Indian, Black, White, etc. <b>Specify: BLACK</b>																								
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) -12- College (1-4 or 5+) -0-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DRIVER</b>				16b. Kind of Business/Industry <b>TRANSPORTATION</b>																								
17. Father's Name (First, Middle, Last) <b>ROBERT SMITH</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>LILLIAN THROWER</b>																											
19a. Informant's Name/Relationship (Type, Print) <b>LORETTA GALES(SISTER)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4227 LABYRINTH RD. BALTIMORE, MARYLAND 21215</b>																											
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST VETERANS</b>			20c. Location - City or Town, State <b>7-22-99 OWINGS MILLS, MARYLAND</b>																										
21. Signature of Funeral Service Licensee <b>[Signature]</b>					22. Name and Address of Facility <b>PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</b>																											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Atherosclerotic Cardiovascular dis.</b></td> <td><b>years</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>Hypertension</b></td> <td><b>years</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td><b>Insulin Dependant Diabetes</b></td> <td><b>years</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Atherosclerotic Cardiovascular dis.</b>	<b>years</b>	Due to (or as a consequence of):			b.	<b>Hypertension</b>	<b>years</b>	Due to (or as a consequence of):			c.	<b>Insulin Dependant Diabetes</b>	<b>years</b>	Due to (or as a consequence of):			d.			
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Atherosclerotic Cardiovascular dis.</b>	<b>years</b>																													
	Due to (or as a consequence of):																															
	b.	<b>Hypertension</b>	<b>years</b>																													
	Due to (or as a consequence of):																															
c.	<b>Insulin Dependant Diabetes</b>	<b>years</b>																														
Due to (or as a consequence of):																																
d.																																
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>																																
24a. Was an autopsy performed? <b>1 Yes 2 No</b>																																
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>																																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>																																
26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>																																
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred																								
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																										
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>																																
29b. Signature and title of certifier <b>Amaton N. Naeem</b>				29c. License number <b>D15503</b>		29d. Date signed (Month, Day, Year) <b>July 16, 1999</b>																										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AMATON - NOUR NAEEM, MD 2600 LIBERTY HATS. AVE BALTA MD 21212</b>																																
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>[Signature]</b>																														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22402

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Harold, Slayton</b>				2. Date of Death Month <b>July</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>1000</b>	
4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Bayview</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
5. Social Security Number <b>161-22-8492</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 16, 1930</b>	
9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>							
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Odenton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>521 N. Patuxent Road</b>				10f. Zip Code <b>21113</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1948-68</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Master Sergeant</b>		16b. Kind of Business/Industry <b>US Army</b>	
17. Father's Name (First, Middle, Last) <b>Raymond Willard Slayton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Leah Mae Keefer</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Elizabeth R. Slayton (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>521 N. Patuxent Road, Odenton, MD 21113</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Epiphany Cemetery</b>		Date <b>07/16</b>		20c. Location - City or Town, State <b>Odenton, MD</b>	
21. Signature of Funeral Service Licensee <b>Thomas A. Hardesty</b>				22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardiopulmonary Arrest</b> Due to (or as a consequence of):  b. <b>Severe Cardiomyopathy</b> Due to (or as a consequence of):  c. <b>Ischemic Colitis</b> Due to (or as a consequence of):  d.  Approximate Interval Between Onset and Death <b>may you 7/6/99</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Grace W. MD</b>		29c. License number <b>98082</b>		29d. Date signed (Month, Day, Year) <b>July 13, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>The Johns Hopkins Bayview Medical Center</b>							
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>Benjamin S. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



State of Maryland / Department of Health and Mental Hygiene

## Reg. No.

99 22403

1. Decedent's Name (First, Middle, Last) <b>CARRIE SMITH</b>		2. Date of Death Month <b>JULY</b> Day <b>11</b> Year <b>99</b>		3. Time of Death <b>9:30 AM</b>											
4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN WSS Home</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>BC</b>										
5. Social Security Number <b>217-26-3924</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> (Yrs.)		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>4/10/1925</b>		9. Birthplace (State or Foreign Country) <b>NO. CAROLINA</b>			
Usual Residence of Decedent															
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>1601 E. Belvedere</b>				10f. Zip Code <b>21239</b>				10g. Citizen of What Country? <b>U.S.A.</b>							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+) <b>N/A</b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LAUNDRY WORKER</b>				16b. Kind of Business/Industry <b>LAUNDRY</b>					
17. Father's Name (First, Middle, Last) <b>Neal H. Smith</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy Williams</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Lucille McLean (sister)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5553 MIDWOOD AVE. BALTO., MD. 21212</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>				Date <b>7/16/99</b>		20c. Location - City or Town, State <b>Baltimore, MD.</b>					
21. Signature of Funeral Service Licensee <b>Joseph Crummett</b>						22. Name and Address of Facility <b>Bells Funeral Home 1129 N. CAROLINE ST. BALTO., MD. 21213</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Renal failure</b> a. <b>Renal failure</b> SEPSIS Due to (or as a consequence of): b. <b>RENAL FAILURE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death <b>&gt; 3 yrs</b> <b>3 yrs</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown												24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier <b>Joseph Crummett</b>				29c. License number <b>D30661</b>				29d. Date signed (Month, Day, Year) <b>July 13th 1999</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>5601 Loch Raven Blvd. Baltimore, Md - 21239</b>															
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>				32. Registrar's Signature <b>Barbara S. Sparks</b>											

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Physician  
/Medical  
Examiner

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DMMH 16 Rev 6/95

ORIGINAL

epc-

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2100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22404

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Emil Sibila

2. Date of Death

Month

Day

Year

July

14

1999

3. Time of Death

4:25 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

083-20-9349

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 10, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

308 CrestWood Drive

10f. Zip Code

21040

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

11

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Thomas Emil Sibila

18. Mother's Name (First, Middle, Maiden Surname)

Aila Taka-aho

19a. Informant's Name/Relationship (Type, Print)

Eileen L. Sibila (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

308 CrestWood Drive, Edgewood, Maryland 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Lawn Cemetery

Date

7/17/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John W. Burkowski

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coma

Due to (or as a consequence of):

6 weeks

c. Status Epilepticus

Due to (or as a consequence of):

6 weeks

d. Cerebral Vascular Accident

Due to (or as a consequence of):

6 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. B. B. Dooley MD

29c. License number

D0054808

29d. Date signed (Month, Day, Year)

July, 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ruth A. Balfour - Dorsey, MD 504 Realm Court East, Odenton MD

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22405

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gordon H. Shoemaker</b>				2. Date of Death Month <b>July</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>10:59A</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>213-05-6758</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>2-11-1911</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Gaithersburg</b>		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>7239 Cypress Hill Drive</b>				10f. Zip Code <b>20879</b>		10g. Citizen of What Country? <b>U.S.A</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Head Department Transportation</b>		16b. Kind of Business/Industry <b>Government</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Clark</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Vivian A. Carter - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20879 7239 Cypress Hill Drive Gaithersburg, MD</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. Location - City or Town, State <b>7-16-99 Arbutus, MD</b>		21. Signature of Funeral Service Licensee <b>John B. Johnson</b>		
	22. Name and Address of Facility <b>March F.H. West 4300 Wabash Avenue Balto, MD 21215</b>		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. <b>Sepsis</b> Due to (or as a consequence of): <b>Adult respiratory distress syndrome</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Adult respiratory distress syndrome</b> Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Eddy Bullock, MD</b>		29c. License number <b>P12308</b>		29d. Date signed (Month, Day, Year) <b>July 12, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Eddy Bullock, MD 2401 West Belvedere Avenue Baltimore Maryland 21215</b>									
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>Benita B. Sparks</b>							

Shoemaker, Gordon  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

444 10



MARCH Y. SMITH  
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22406

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>March Yvette Smith</i>		2. Date of Death Month <i>JULY</i> Day <i>12</i> Year <i>1999</i>		3. Time of Death <i>12:33 P</i>	
4a. Facility Name (If not institution, give street and number) <i>SINAI HOSPITAL</i>			4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death
5. Social Security Number <i>220-72-6830</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>36</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>12-5-1962</i>
9. Birthplace (State or Foreign Country) <i>MD</i>					
10a. State <i>MD</i>		10b. County <i>NA</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>4605 Post Road</i>		10f. Zip Code <i>21215</i>	
10g. Citizen of What Country? <i>U.S.A</i>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>NA</i>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>haundress</i>		16b. Kind of Business/Industry <i>Nursing Home</i>		17. Father's Name (First, Middle, Last) <i>William Smith</i>	
18. Mother's Name (First, Middle, Maiden Surname) <i>Cassandra Wilson</i>		19a. Informant's Name/Relationship (Type, Print) <i>George Lawson-El-Friend</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4605 Post Road Baltimore, MD 21215</i>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Memorial Park</i>		20c. Location - City or Town, State <i>7-17-99 Arbutus, MD</i>	
21. Signature of Funeral Service Licensee <i>John March</i>		22. Name and Address of Facility <i>March F.H. West 4300 Wabash Avenue Baltimore, MD 21215</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Pulmonary Thromboembolism</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier <i>Thornton M. King</i>		29c. License number <i>O.C.M.E</i>	
29d. Date signed (Month, Day, Year) <i>JULY 13, 1999</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Thornton M. King</i>		31. Date filed (Month, Day, Year) <i>JUL 16 1999</i>	
32. Registrar's Signature <i>Benita B. Sparks</i>		33. State Registrar <i>State Registrar</i>		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22407

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGINIA S. SHIFFLETT</b>						2. Date of Death Month Day Year <b>June 25 1999</b>		3. Time of Death <b>0330 A</b>														
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Hospital</b>						4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>														
Funeral Director	5. Social Security Number <b>226-50-8467</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.														
	6. Date of Birth (Month, Day, Year) <b>Aug. 15 1914</b>						9. Birthplace (State or Foreign Country) <b>Virginia</b>																
Usual Residence of Decedent																							
10a. State <b>VA</b>		10b. County <b>Greene</b>		10c. City, Town or Location <b>Dyke</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
10e. Street and Number <b>Box 58</b>				10f. Zip Code <b>22935</b>				10g. Citizen of What Country? <b>USA</b>															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>				16b. Kind of Business/Industry <b>own home</b>															
17. Father's Name (First, Middle, Last) <b>Luther Shifflett</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Shifflett Shifflett</b>																	
19a. Informant's Name/Relationship (Type, Print) <b>Ernest J. Shifflett/Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7504 Julia Terr/Rockville, MD 20855</b>																	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Cem.</b>		20c. Location - City or Town, State <b>6/28/99 Dyke, VA</b>															
21. Signature of Funeral Service Licensee <i>[Signature]</i> M00092						22. Name and Address of Facility <b>Ryan Funeral Home/P.O.Box 33, Quince, VA</b>																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Septic shock</b></td> <td>Approximate Interval Between Onset and Death <b>Hours</b></td> </tr> <tr> <td>b.</td> <td><b>Visceral Perforation</b></td> <td><b>Hours</b></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Septic shock</b>	Approximate Interval Between Onset and Death <b>Hours</b>	b.	<b>Visceral Perforation</b>	<b>Hours</b>	c.			d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Septic shock</b>	Approximate Interval Between Onset and Death <b>Hours</b>																				
	b.	<b>Visceral Perforation</b>	<b>Hours</b>																				
	c.																						
	d.																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD, multiorgan failure, dementia, congestive heart failure, anemia,</b>																							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred															
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																							
29b. Signature and title of certifier <i>[Signature]</i> Physician				29c. License number <b>D0052255</b>				29d. Date signed (Month, Day, Year) <b>June 25, 1999</b>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. E. J. M.D. 8609 2nd Ave. #404B Silver Spring MD 20910</b>																							
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>				32. Registrar's Signature <i>[Signature]</i>																			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, R

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA MARIA SPENCER

2. Date of Death

JUL 13 1999

3. Time of Death

12:10 AM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

549-46-7077

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-22-25

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

VA

10b. County

Fairfax

10c. City, Town or Location

Reston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1712 Lakeshore Dr.

10f. Zip Code

20190

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Paolo Maria Guala

18. Mother's Name (First, Middle, Maiden Surname)

Vittoria Avalla

19a. Informant's Name/Relationship (Type, Print)

Paul A. Spencer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12701 Fox Woods Dr., Herndon, VA 20171

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National Columbarium 7/21/99

Date

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Green Funeral Home,  
721 Elden St., Herndon, VA 2017023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

METASTATIC PANCREATIC CANCER

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-0054195

29d. Date signed (Month, Day, Year)

13 Jul 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNE T. FOX, LT, MC, USNR

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry E. Tobias				2. Date of Death Month: July Day: 15 Year: 1999		3. Time of Death 236a					
	4a. Facility Name (If not institution, give street and number) Baltimore VA Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City					
Funeral Director	5. Social Security Number 374-05-2312		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 24, 1914		9. Birthplace (State or Foreign Country) South Carolina			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	10e. Street and Number 2206 Presstman St.			10f. Zip Code 21216		10g. Citizen of What Country? USA						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Afro-American					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker Private Co.			16b. Kind of Business/Industry						
	17. Father's Name (First, Middle, Last) Henry Tobias				18. Mother's Name (First, Middle, Maiden Surname) Minnie Tobias							
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. David Nixon (nephew)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Oak Run Rd. Laurel, Md. 20724								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus		20c. Date 7/20/99		20d. Location - City or Town, State Balto. Md.					
	21. Signature of Funeral Service Licensee Joseph L. Russ			22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Sepsis  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death 24 Hours			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Myelodysplastic Syndrome								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J. E. Ash						29c. License number P11753		29d. Date signed (Month, Day, Year) July 15, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Goodman, M.D. BVAMC 10 N. Greene St Baltimore, MD 21201											
	31. Date filed (Month, Day, Year) JUL 16 1999				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22410

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roger Thomison</b>				2. Date of Death Month <b>July</b> Day <b>11</b> Year <b>1999</b>		3. Time of Death <b>7:29 pm</b>													
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death													
Funeral Director	5. Social Security Number <b>220-64-7304</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>43</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-25-55</b>													
	9. Birthplace (State or Foreign Country) <b>FL.</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>													
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2104 E. Jefferson Street</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>														
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		College (14 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>NA</b>														
17. Father's Name (First, Middle, Last) <b>Robert Thomison, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Doris Ready Warren</b>																
19a. Informant's Name/Relationship (Type, Print) <b>Ward Warren</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5104 Laurel Avenue Baltimore, MD. 21215</b>																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery 07-16-99</b>		20c. Location - City or Town, State <b>Lansdowne, MD</b>		20d. Date <b>07-16-99</b>														
21. Signature of Funeral Service Licensee <b>Heady Warner</b>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Aspergillus</b></td> <td>Approximate Interval Between Onset and Death <b>11 Days</b></td> </tr> <tr> <td>b.</td> <td><b>AIDS</b></td> <td><b>4 years</b></td> </tr> <tr> <td>c.</td> <td><b>HIV</b></td> <td><b>6 years</b></td> </tr> <tr> <td>d.</td> <td><b>Intravenous Drug Use</b></td> <td><b>12 years</b></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	<b>Aspergillus</b>	Approximate Interval Between Onset and Death <b>11 Days</b>	b.	<b>AIDS</b>	<b>4 years</b>	c.	<b>HIV</b>	<b>6 years</b>	d.	<b>Intravenous Drug Use</b>	<b>12 years</b>
Immediate Cause (Final disease or condition resulting in death)	a.	<b>Aspergillus</b>	Approximate Interval Between Onset and Death <b>11 Days</b>																	
	b.	<b>AIDS</b>	<b>4 years</b>																	
	c.	<b>HIV</b>	<b>6 years</b>																	
	d.	<b>Intravenous Drug Use</b>	<b>12 years</b>																	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure.</b>																				
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. Signature and title of certifier <b>[Signature] MD</b>				29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>July 11, 1999</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jacob Mishell, MD, 600 N. Wolfe St., Baltimore MD 21205</b>																				
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>[Signature]</b>																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22411

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Spivey Taylor

2. Date of Death

Month Day Year

July 12 1999

3. Time of Death

9:06

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-16-7990

6. Sex

1 ☐ M ☒ F

7. Age (in yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 01-13-1906

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2905 Woodlawn Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10 th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HomeMaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Zebalon Wilder

18. Mother's Name (First, Middle, Maiden Surname)

Martha Manley

19a. Informant's Name/Relationship (Type, Print)

Patricia Harper- Young Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11907 -I Tarragon Rd. Reisterstown, Md. 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. Nat. Mem. Park Cem. 7/16/99

Date

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Caple Funeral Service

5502 Winner Ave. Balto., Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Overwhelming Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GANGRENE

Due to (or as a consequence of):

c. Peripheral Vascular Disease

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

July 12, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARCUS D. SMITH, MD 2401 Belyvedere, Baltimore, MD 21215

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

October 10th 1901

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 9th inst. in relation to the above matter.  
I am sorry that I cannot give you a more definite answer at this time, but I am sure that you will understand my position.

I am, Sir, very respectfully,  
Yours truly,  
J. H. [Signature]

I am, Sir, very respectfully,  
Yours truly,  
J. H. [Signature]

Very truly,  
J. H. [Signature]



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVELYN TRUSTY</b>				2. Date of Death Month Day Year <b>JULY 12, 1999</b>		3. Time of Death <b>1925 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>1722 N. WOLFE STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N.A</b>		
Funeral Director	5. Social Security Number <b>218 12 7013</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>1-16-20</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N.A.</b>		10c. City, Town or Location <b>Balt.</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1722 N. Wolfe St.</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TAILOR</b>				16b. Kind of Business/Industry <b>CLOTHING</b>		
	17. Father's Name (First, Middle, Last) <b>CLIFFORD TRUSTY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BARBARA SPENCER</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>TRESSIE NELSON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1111 PARK AVE APT 314 BALTO MD 21217</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. CALVARY CEM</b>		Data <b>7/16/99</b>		20c. Location - City or Town, State <b>A.A. COUNTY MD</b>		
	21. Signature of Funeral Service Licensee <b>Joseph B. Locks</b>				22. Name and Address of Facility <b>Joseph B. Locks 314 1304th Central Ave</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <b>DISSECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Wayne Melkell MD</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WALTERS D. KAPRI 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>B. Sparks</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22413

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLARENCE W. TAYLOR JR.

2. Date of Death

Month Day Year  
JULY 13 1999

3. Time of Death

3:55 pm

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE, CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-58-7136

6. Sex

M 2 F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAR 21 1954

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE CO

10c. City, Town or Location

DUNDALK

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

8012 NORRIS LANE

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

TRANSPORTATION

17. Father's Name (First, Middle, Last)

CLARENCE W. TAYLOR, SR

18. Mother's Name (First, Middle, Maiden Surname)

RUTH TAYLOR

19a. Informant's Name/Relationship (Type, Print)

Jane C. Daye/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2818 Lodgefarm Rd., Baltimore, Maryland 21219

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HOLLY HILLS CEMETERY

Date

7-19-99

20c. Location - City or Town, State

MIDDLE RIVER, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA  
1206 W NORTH AVENUE23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. BRAINSTEM HERNIATION

Due to (or as a consequence of):

4 hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. INTRA-CEREBRAL HEMORRHAGE

Due to (or as a consequence of):

9 DAYS

c. Hypertension

Due to (or as a consequence of):

10 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ENDOCARDITIS

INJECTION DRUG ABUSE

HEPATITIS C VIRUS

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

5 Pending  
investigation

2 Accident

6 Could not be  
determined

3 Suicide

4 Homicide

28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JULY 13 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SACER MISHALL, MD, 600 N. WOLFE ST., BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

P. Sparks

State  
RegistrarClarence W. Taylor Jr.  
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22414

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Kenneth H. Tibbs

2. Date of Death

July 17 1999

3. Time of Death

6:42 AM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

227-50-3423

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 30, 1940

9. Birthplace (State or Foreign Country)

Lynchburg, Va.

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel Co.

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

759 221st. Street

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hand Machine Repair

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

Jesse Tibbs

18. Mother's Name (First, Middle, Maiden Surname)

Kizzie Miles

19a. Informant's Name/Relationship (Type, Print)

Mrs. Georgia Tibbs

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

759 221st. Street Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery July 17, 1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Valerie J. Olynick

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.  
3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey Buggs MD

29c. License number

D28640

29d. Date signed (Month, Day, Year)

July 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2414 Hightee Ct.

Crofton MD 21114

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22415

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clyde Arvol Turner				2. Date of Death Month Day Year July 15, 1999				3. Time of Death 2:00 p.m.	
	4a. Facility Name (If not institution, give street and number) Randallstown Center				4b. City, Town, or Location of Death Randallstown				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 228-05-5064		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Nov. 1, 1917		9. Birthplace (State or Foreign Country) Kentucky		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Middle River	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 422 Wampler Road				10f. Zip Code 21220		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor				16b. Kind of Business/Industry Container Manufacturer	
	17. Father's Name (First, Middle, Last) George Turner				18. Mother's Name (First, Middle, Maiden Surname) Mamie Davis					
	19a. Informant's Name/Relationship (Type, Print) Jerry Turner (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Homberg Avenue, Baltimore, Maryland 21221					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Gard		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 7/19/99			
	21. Signature of Funeral Service Licensee John W. Buckowski				22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALCOHOLIC DEMENTIA Due to (or as a consequence of): b. ALCOHOL ABUSE Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death YRS YRS					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier K. ZONIES				29c. License number D20333		29d. Date signed (Month, Day, Year) 7/16/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 GREENBEND PIKEVILLE MD		31. Date filed (Month, Day, Year) JUL 16 1999				32. Registrar's Signature G. Sparks				
State Registrar										

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22416

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Louis E. Ullmann</b>				2. Date of Death Month Day Year <b>July 14 1999</b>		3. Time of Death <b>12:00 PM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Heartlands Assisted Living Center</b>				4b. City, Town, or Location of Death <b>Ellicott City</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>127-12-4549</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 21, 1912</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent							
10e. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3004 N. Ridge Rd.</b>				10f. Zip Code <b>21043</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Small Business Owner</b>		16b. Kind of Business/Industry <b>Sales / Refrigeration</b>		
17. Father's Name (First, Middle, Last) <b>Leopold Ullmann</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Olive Franz</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Castellano / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>100 Beaumont Ave. Catonsville, MD. 21228</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>July 20 1999</b>		20c. Location - City or Town, State <b>Catonsville, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Hepatitis</b> Due to (or as a consequence of): <b>Pancreatic tumour</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>6 months</b>  a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <b>1 wk</b> <b>6 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery disease</b> <b>Dementia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Assis. Lving.</b>						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier  <b>Sandra Sattin MD</b>						
29c. License number <b>035309</b>		29d. Date signed (Month, Day, Year) <b>7.16.99</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sandra Sattin MD 2800 N Ridge Rd Ellicott City MD 21043</b>								
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature  <b>B. Sparks</b>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

*[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]*

*[Handwritten signature or name.]*

Feb 2 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22417

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Tinnie Watson</b>				2. Date of Death Month <b>July</b> Day <b>13</b> Year <b>99</b>				3. Time of Death <b>10:35pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Nursing Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>238-64-3314</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>06-24-11</b>		9. Birthplace (State or Foreign Country) <b>NC</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1601 East Belvedere Avenue</b>				10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>			16b. Kind of Business/Industry <b>Self-employed</b>		
	17. Father's Name (First, Middle, Last) <b>Rufus Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lizzie Williams</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Irene Fourgurean</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21239</b> <b>5716 Maple Hill Road Baltimore, Maryland</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee <b>Joseph R. Walter Jr</b>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): <b>c. Diabetes Mellitus</b> Due to (or as a consequence of): <b>d. Hypertension</b>									
	23b. Approximate Interval Between Onset and Death <b>1 week</b> <b>Years</b> <b>Years</b> <b>Years</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Disease</b> <b>Atrial Fibrillation</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Thomas S. Wilson MD</b>		29c. License number <b>D40277</b>		29d. Date signed (Month, Day, Year) <b>July 14, 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas S. Wilson MD 5601 Loch Raven Blvd Baltimore, MD 21239</b>										
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>James B. Sparks</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22418

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Wesley Wilson

2. Date of Death

July 13, 1999 9:40 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Deaton Medical Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-64-0520

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

04-05-1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3201 Phelps Lane

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Baltimore City Public School System

17. Father's Name (First, Middle, Last)

Jesse Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Ethel L. Williams

19a. Informant's Name/Relationship (Type, Print)

Ethel L. Wilson/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3201 Phelps Lane, Baltimore, Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

7/19/99

20c. Location - City or Town, State

Arbutus, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

William C. Brown Community Funeral Home

1206 W. North Avenue, Baltimore, Md. 21217

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small cell cancer of lung with metastases to bone

Due to (or as a consequence of):

b. Diabetes mellitus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate interval between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D34974

29d. Date signed (Month, Day, Year)

July, 14th, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CHARU MENA, MD 8775 cloudleaf Ct #224, Columbia, MD 21045

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

*[Signature]*

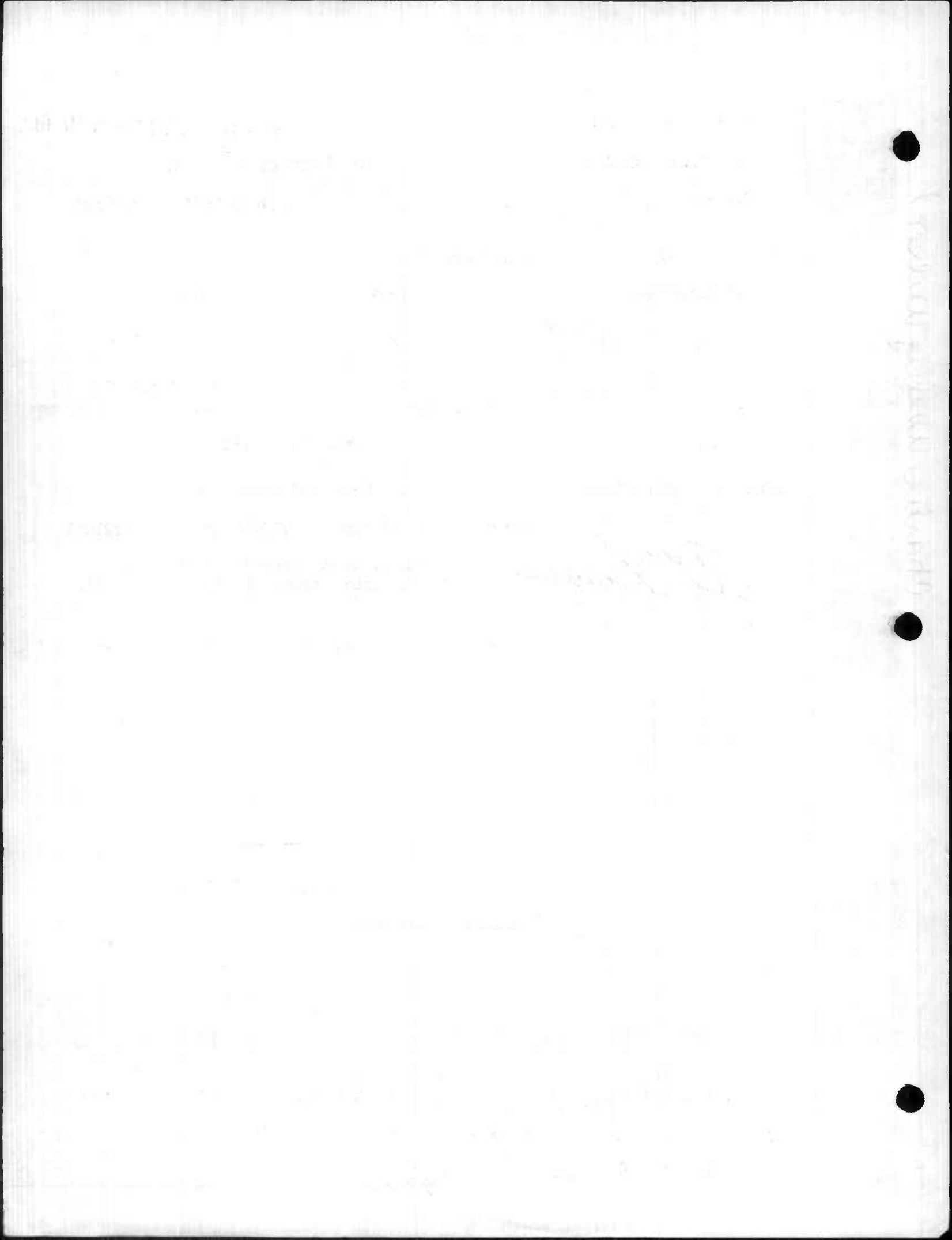
State  
Registrar

Charles Wesley Wilson  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 33a or 33b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

AH3





ADH  
DAVID WILKINS  
99-4094-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#8 perFH G773 7/23/99 EW

Certificate of Death

Reg. No.

99 22419

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Benjamin Wilkins				2. Date of Death Month Day Year JULY 13, 1999		3. Time of Death 2218 PM	
	4a. Facility Name (If not institution, give street and number) 312 CEDAR RUN PLACE				4b. City, Town, or Location of Death Catonsville		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 212-92-6070	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	8. Date of Birth (Month, Day, Year) AUG 20, 1962	9. Birthplace (State or Foreign Country) District of Columbia			
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 312 Cedar Run Place, Apt. M				10f. Zip Code 21228		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Math Teacher		16b. Kind of Business/Industry Education		
17. Father's Name (First, Middle, Last) Michael C. Wilkins				18. Mother's Name (First, Middle, Maiden Surname) Marcia Paulette Schein				
19a. Informant's Name/Relationship (Type, Print) Michael C. Wilkins/father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 787 Martin Court West Severn, MD 21144				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 07/15/99		20c. Location - City or Town, State Baltimore, MD				
21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Drowning Complicating Due to (or as a consequence of): b. Multiple Sclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 7/13/99		28b. Time of Injury 2215 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred Subject drowned in bathtub		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home. 312 Cedar Run Pl		28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, Md		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier J. Pestaner, M.D.				29c. License number OCME		29d. Date signed (Month, Day, Year) JULY 14, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 16 1999				32. Registrar's Signature G. Spauls				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22420

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey Welch

2. Date of Death

Month Day Year  
July 14, 1999

3. Time of Death

0743

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-44-5593

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
May 24, 1908

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5555 Friendship Blvd.

10f. Zip Code

20815

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

State Department

17. Father's Name (First, Middle, Last)

Unknown Eng

18. Mother's Name (First, Middle, Maiden Surname)

Ella Larson

19a. Informant's Name/Relationship (Type, Print)

Mary Garrison (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4300 Claggett Pineway, University Park, MD 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Our Lady of Sorrows

Date

07/16

20c. Location - City or Town, State

Owensville, MD

21. Signature of Funeral Service Licensee

K. S. Ore

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Years

Due to (or as a consequence of):

b. Congestive Heart Failure

Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Joseph Rothstein

29c. License number

D34174

29d. Date signed (Month, Day, Year)

7/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Joseph Rothstein 8600 Old Georgetown Road

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

S. A. Spauls

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22421

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY R WALTER</b>				2. Date of Death Month Day Year <b>07 13 99</b>		3. Time of Death <b>4:59 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>PLEASANT VOIR NURSING HOME</b>				4b. City, Town, or Location of Death <b>MIDDLE RIVER MD.</b>		4c. County of Death <b>CHARLOTTE</b>		
Funeral Director	5. Social Security Number <b>208 22 2323</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 30, 1910</b>		
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>10127 Bird River Rd.</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembler</b>		16b. Kind of Business/Industry <b>Bendix Corp.</b>		17. Father's Name (First, Middle, Last) <b>Elmer Mackneer</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Brought</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Ruth Rose (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10127 Bird River Rd. Baltimore, Md. 21220</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee <b>John W. Burkowski</b>		22. Name and Address of Facility <b>Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Dehydration and Sepsis</b> Due to (or as a consequence of): <b>END STAGE ALZHEIMERS DISEASE</b> Due to (or as a consequence of): <b></b> Due to (or as a consequence of): <b></b> Due to (or as a consequence of): <b></b>		Approximate Interval Between Onset and Death <b>2-3 DAYS</b>			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b></b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b></b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b></b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Ronald E. Miller M.D.</b>		29c. License number <b>D26499</b>		29d. Date signed (Month, Day, Year) <b>7-13-99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ronald E. Miller 4 Colwell Dr. Mt Airy Rd 21771</b>		31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>Jinerva B. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22422

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ESTELLE J. WALLER

2. Date of Death

Month Day Year  
JULY 12, 1999

3. Time of Death

4:00 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

708 Towering Oaks Court

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

094-18-8543

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 8, 1911

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

708 Towering Oaks Court

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Severn Food Market

17. Father's Name (First, Middle, Last)

Joseph Jozwiak

18. Mother's Name (First, Middle, Maiden Surname)

Frances Montgomery

19a. Informant's Name/Relationship (Type, Print)

David Wilson - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

708 Towering Oaks Ct., Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Cemetery

Date

7/16

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

Kelly Gregory Fink

22. Name and Address of Facility

Fink Funeral Home, PA

426 Crain Hwy., SW, Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy + Heart Failure

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Heart Disease

4 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier

David A. Schwartz, MD

29c. License number

H 17744

29d. Date signed (Month, Day, Year)

7/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID A. Schwartz, MD 300 Hospital Rd Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22423

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PATRICIA ELAINE Williams</b>				2. Date of Death Month <b>JULY</b> Day <b>13</b> Year <b>1999</b>				3. Time of Death <b>6:01 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>				4b. City, Town, or Location of Death <b>Farmdale</b>				4c. County of Death <b>Balto Co</b>	
Funeral Director	5. Social Security Number <b>053-34 9259</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02/09/1942</b>		9. Birthplace (State or Foreign Country) <b>New York</b>	
	Usual Residence of Decedent									
10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Woodlawn</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>6914 Dogwood Road</b>				10f. Zip Code <b>21244</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housekeeper</b>			16b. Kind of Business/Industry <b>Hotel</b>			
17. Father's Name (First, Middle, Last) <b>Arthur Goebler</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Larry Williams/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6914 Dogwood Road, Balto, Md 21244</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Washington</b>		Date <b>7/16</b>		20c. Location - City or Town, State <b>Laural, Md</b>		
21. Signature of Funeral Service Licensee <b>Mez K. Marshall</b>				21. Name and Address of Facility <b>Sterling-Ashton Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md 21228</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>VENTRICULAR FIBRILLATION</b> Due to (or as a consequence of): b. <b>Cardiomyopathy</b> Due to (or as a consequence of): c. <b>Diabetes Mellitus</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death  <b>2 yr</b> <b>10 yr</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Asthma, Severe</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature]</b>		29c. License number		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK E. ALSS (in MD) 1838 Greentree Road, Baltimore Md</b>										
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>				32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22424

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAVERNE WINDER - CAREY</b>				2. Date of Death Month <b>July</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>11:22 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLS TOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>RIR-80-4673</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>31</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>06-14-62</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>41 N. ARLINGTON AVENUE</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4or 5+) <b>1 YR</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CUSTOMER SERVICE REP.</b>		16b. Kind of Business/Industry <b>ICON</b>		
17. Father's Name (First, Middle, Last) <b>MCCLENT WINDER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>INETTA BARNES</b>				
19a. Informant's Name/Relationship (Type, Print) <b>DAVID CAREY   HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>41 N. ARLINGTON AVE. BALTO. MD. 21229</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		Date <b>7-17-99</b>		20c. Location - City or Town, State <b>BALTO. MD</b>		
21. Signature of Funeral Service Licensee <b>Vaughn C. Greene</b>				22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>pulmonary edema</u></b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>								Approximate Interval Between Onset and Death <b>7 day</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HIV POSITIVE; PANCYTOPENIA PANCREATITIS</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>[Signature] MD</b>				29c. License number <b>D19502</b>		29d. Date signed (Month, Day, Year) <b>July 13, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ORLANDO B. CONAWAY MD NORTHWEST HOSPITAL CENTER RANDALLS TOWN MD. 21133</b>								
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

7-16

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22425

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annamae L. Warren		2. Date of Death Month Day Year July 14, 1999		3. Time of Death 3:05pm
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center		4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 220-18-3513	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) 5-11-26	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Middle River		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 1111 Reamer Rd.		10f. Zip Code 21220		10g. Citizen of What Country? USA
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) (unk.) Wakefield		18. Mother's Name (First, Middle, Maiden Surname) (unk.) Gephardt		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Richard Warren / son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 Reamer Rd. Baltimore, MD 21220		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State 7-17-99 Parkville, MD
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensed Dennis S. Kelly		22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2 hrs.		
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Mark Leffer M.D.		29c. License number 36538		29d. Date signed (Month, Day, Year) July 14, 1999
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Marc Leffer 9000 Franklin Square Drive Baltimore, Maryland 21237				
State Registrar	31. Date filed (Month, Day, Year) JUL 16 1999		32. Registrar's Signature B. Sparks		

ORIGINAL

602121



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22426

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Mary Wilson				2. Date of Death Month Day Year July 12 1999				3. Time of Death 10:10 pm	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Timonium				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-03-6397		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) June 15, 1912		9. Birthplace (State or Foreign Country) Md.		Usual Residence of Decedent		10a. State Md.		10b. County Baltimore	
To Be Completed by Funeral Director	10c. City, Town or Location Timonium				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2300 Dulaney Valley Rd.		10f. Zip Code 21093	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) David Remington				18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Finnigan		19a. Informant's Name/Relationship (Type, Print) Gloria Huber/ Niece			
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2749 E. Church Lane White Hall, Md. 21161				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Cemetery		20c. Location - City or Town, State 7-16-99 Timonium, Md.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John C. Miller, Inc. 6415 Belair Rd. Balto., Md. 21206		23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) HOSPICE				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D43725		29d. Date signed (Month, Day, Year) 7/13/99	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093				31. Date filed (Month, Day, Year) JUL 16 1999		32. Registrar's Signature 		33. State Registrar	

ELIZABETH WILSON July 12, 1999 10:10 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

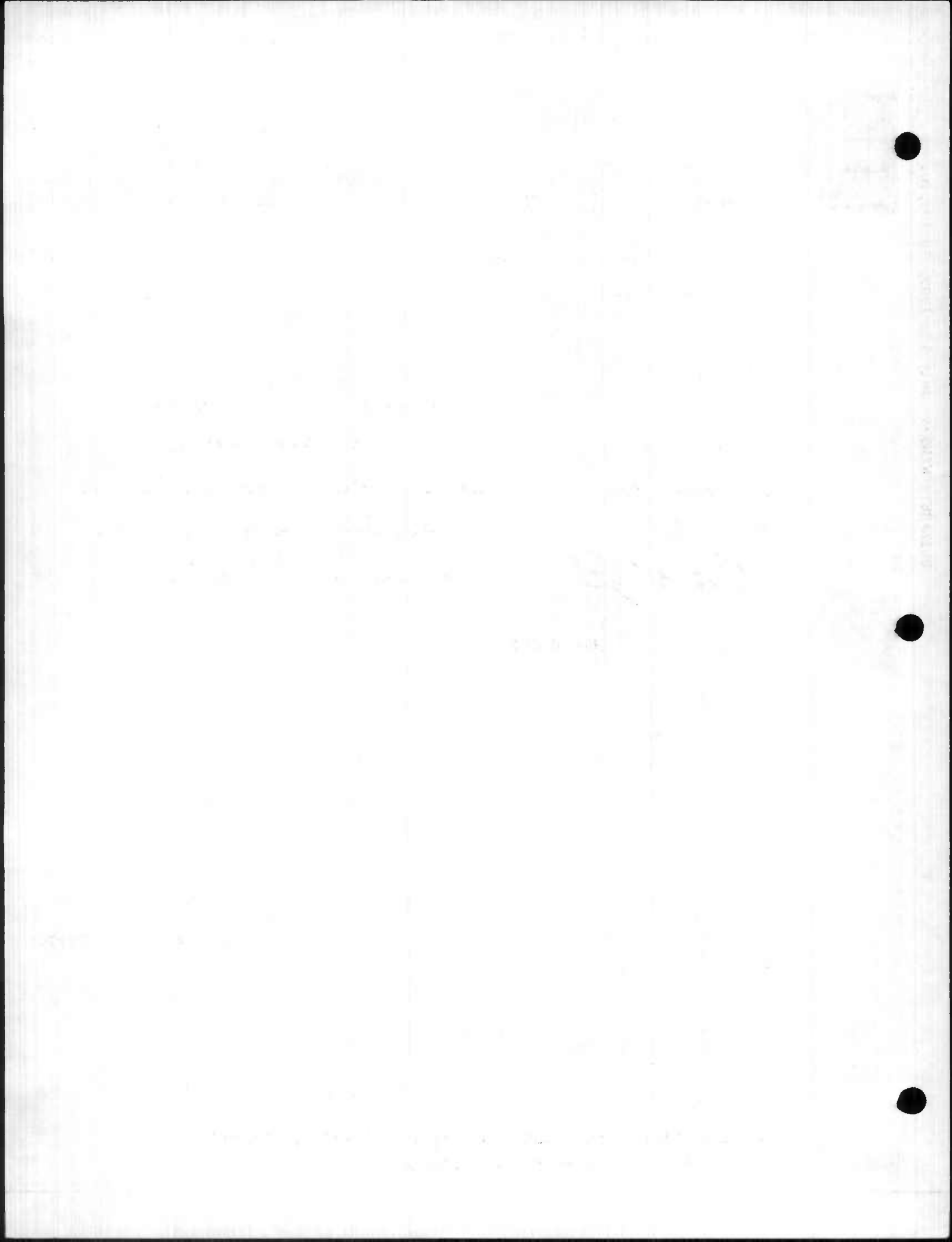
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22427

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Jack YUAN

2. Date of Death

Month  
JUNEDay  
9Year  
1999

3. Time of Death

1:10 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

N/A

6. Sex

1 X M 2 F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

3 40

8. Date of Birth (Month, Day, Year)

JUNE 8, 1999

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 X Yes 2 F No

10e. Street and Number

6 Wisely Square Ct.

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 X Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Xiaofang Yuan / Father

18. Mother's Name (First, Middle, Maiden Surname)

Benzhi Yu

19a. Informant's Name/Relationship (Type, Print)

Xiaofang Yuan / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Wisely Square Ct., Gaithersburg, Md. 20877

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify): released to hospital

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery General Hospital

Date

JUNE 9, 1999

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee

Jim R. Luman

22. Name and Address of Facility

Montgomery General Hospital  
18101 Prince Philip Dr., Olney, Maryland 20832

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO PULMONARY Failure / Non-Viability

Due to (or as a consequence of):

b. Prematurity at nineteen to twenty weeks gestations

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Klinefelter Syndrome (determined by amniocentesis)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 X No

25. Was case referred to medical examiner?

1 Yes 2 X No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending Investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 Yes 2 X No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NON-APPLICABLE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Menfo Imoisili D. D38524

29c. License number

D38524

29d. Date signed (Month, Day, Year)

JUNE 9, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MENFO IMOISILI 18101 Prince Philip Drive, Olney, Maryland 20832

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

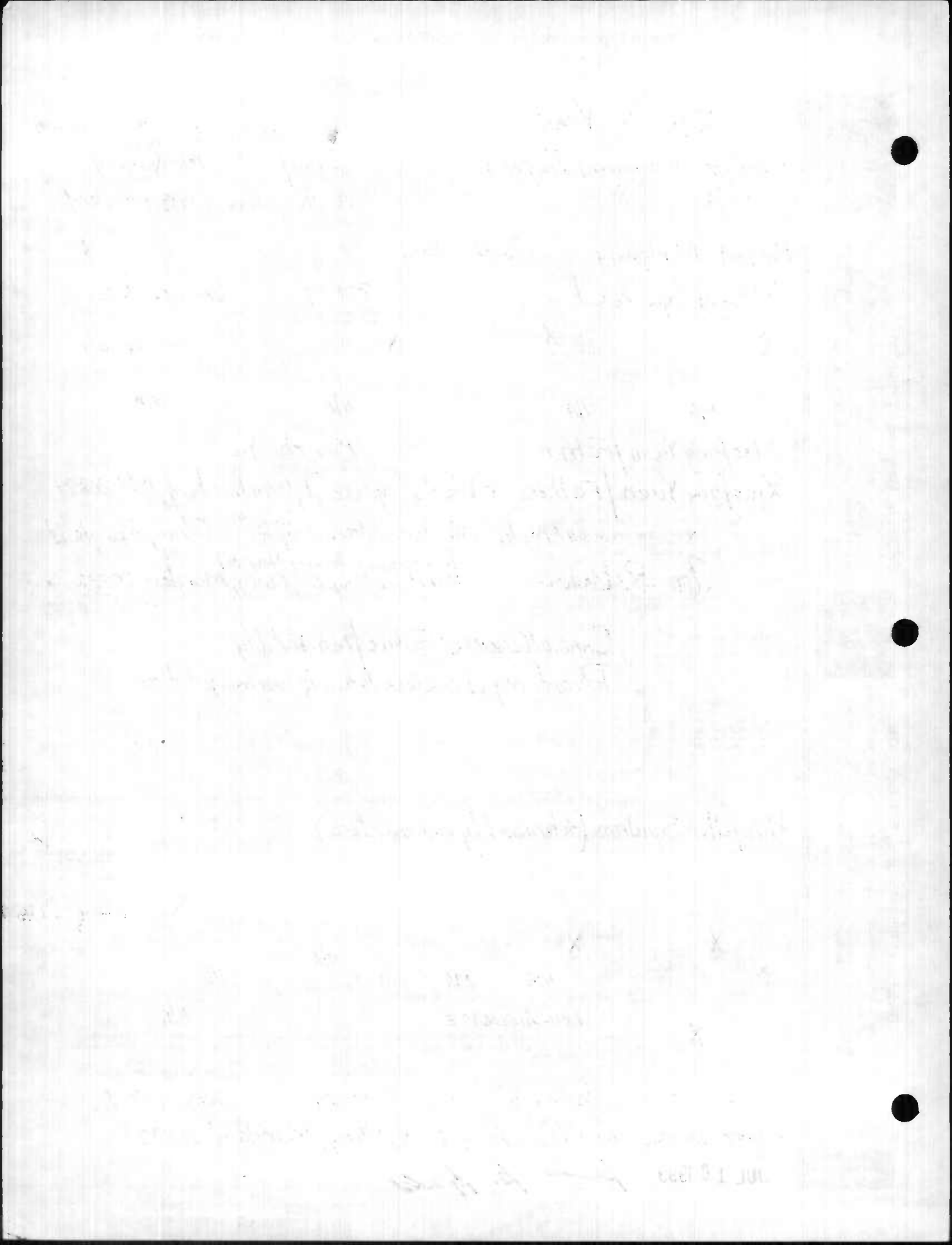
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22428

AMENDED ITEM #1 &amp; #5 PER FH &amp; MD G773 7/27/99 AH

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Fay

YANKOLONIS

Yankolonis

2. Date of Death

Month

Day

Year

July 14, 1999

3. Time of Death

1900 hours

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

174-204-2485

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 15, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

514 Williamsburg Lane

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
216a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Earl Bruaw

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Thumma

19e. Informant's Name/Relationship (Type, Print) Husband  
Benedict A. Yankolonis19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
514 Williamsburg Lane, Odenton, MD 21113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National

Date

7/22

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

Batal J. M.

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD

21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Subarachnoid hemorrhage  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

5 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

Wendy Ziai M.D., Fellow, NCCU

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wendy Ziai M.D., Johns Hopkins Hospital 600 North Broadway, Baltimore MD 21287

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 16 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

21 10 12

10-10-11

Page 2 of 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22429

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Raymond Zakaski</b>				2. Date of Death Month Day Year <b>July 14, 1999</b>		3. Time of Death <b>9:10 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Tacoma Park</b>		4c. County of Death <b>Montgomery Co.</b>		
Funeral Director	5. Social Security Number <b>301.01.9475</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>XX</b>		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8/27/1920</b>		
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>XX</b>		10e. Street and Number <b>1921 Mt. Travers Road</b>		10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>		16b. Kind of Business/Industry <b>Westinghouse</b>		17. Father's Name (First, Middle, Last) <b>Stanley Zakszewski</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Hoderwicz</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Mary Zakaski - wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1921 Mt. Travers Road, Glen Burnie, MD 21060</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		21. Signature of Funeral Service Licensee <i>Kelly Gregory Fink</i> <b>KELLY GREGORY FINK</b>		22. Name and Address of Facility <b>FINK FUNERAL HOME, PA 426 CRAIN HWY., SW., GLEN BURNIE, MD 21061</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Renal Failure</b> Due to (or as a consequence of): f. <b>Sepsis</b> Due to (or as a consequence of): g. <b>Respiratory Insufficiency</b> Due to (or as a consequence of): h. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D41089</b>		29d. Date signed (Month, Day, Year) <b>7/14/99</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Washington Adventist Hospital, 7600 Condit Ave. Takoma Park, MD 20912</b>	
31. Date filed (Month, Day, Year) <b>JUL 16 1999</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

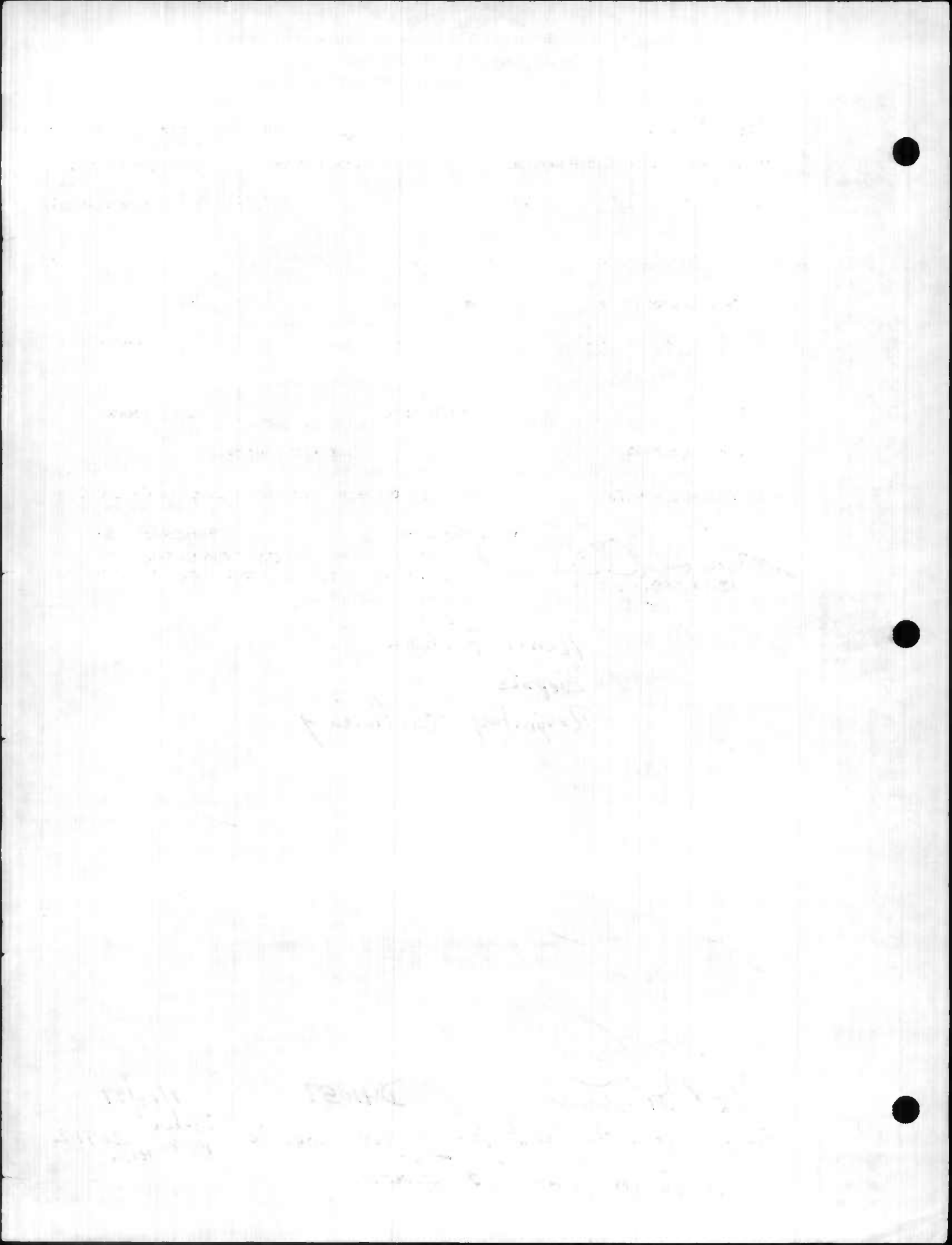
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22430

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NOWLAND ANDERSON</b>				2. Date of Death Month <b>July</b> Day <b>2</b> Year <b>1999</b>		3. Time of Death <b>16<sup>15</sup></b>	
	4a. Facility Name (If not Institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>219-56-5534</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>September 7, 1950</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Cecil</b> 10c. City, Town or Location <b>Elkton</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Street and Number <b>1448 East Old Philadelphia Road</b>		12. Zip Code <b>21921</b>	
13. Merital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		14. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		16. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)		18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-employed dump truck driver</b>		19. Kind of Business/Industry <b>Hauling</b>		20. Father's Name (First, Middle, Last) <b>Carl J. Anderson</b>		
21. Informant's Name/Relationship (Type, Print) <b>Bryan N. Anderson / Nephew</b>		22. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1448 E. Old Philadelphia Road, Elkton, MD 21921</b>		23. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		24. Date of Disposition (Name of cemetery, crematory or other place) <b>July 6 1999</b>		
25. Signature of Funeral Service Licensee 		26. Name and Address of Facility <b>Crouch Funeral Home</b> <b>127 South Main Street, North East, MD 21901</b>		27. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of):  b. <b>PNEUMONIA</b> Due to (or as a consequence of):  c. <b>BULLOUS LUNG DISEASE</b> Due to (or as a consequence of):  d.  Approximate Interval Between Onset and Death  <b>10 DAYS</b>  <b>18 DAYS</b>  <b>&gt; 2 YEARS</b>		28. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
29. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		30. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		31. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		32. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
33. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		34. Date of Injury (Month, Day, Year) <b>July 2, 1999</b>		35. Time of Injury <b>M</b>		36. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
37. Date of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>200 DUNCANNON ROAD BEL AIR, MD 21014</b>		38. Location (Street and Number or Rural Route Number, City or Town, State)		39. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		40. Signature and title of certifier <b>Audrey Liu MD</b>		
41. License number <b>RES-000</b>		42. Date signed (Month, Day, Year) <b>JULY 2, 1999</b>		43. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AUDREY LIU 200 DUNCANNON ROAD BEL AIR, MD 21014</b>		44. Date filed (Month, Day, Year) <b>JUL 06 1999</b>		
45. Registrar's Signature 		46. State Registrar		47. Date filed (Month, Day, Year) <b>JUL 06 1999</b>		48. Registrar's Signature 		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural" or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

The first part of the report is a summary of the work done during the year.

The second part is a detailed account of the work done during the year.

The third part is a summary of the work done during the year.

The fourth part is a summary of the work done during the year.

The fifth part is a summary of the work done during the year.

The sixth part is a summary of the work done during the year.

The seventh part is a summary of the work done during the year.

The eighth part is a summary of the work done during the year.

The ninth part is a summary of the work done during the year.



The tenth part is a summary of the work done during the year.

The eleventh part is a summary of the work done during the year.

The twelfth part is a summary of the work done during the year.

The thirteenth part is a summary of the work done during the year.

The fourteenth part is a summary of the work done during the year.

The fifteenth part is a summary of the work done during the year.

The sixteenth part is a summary of the work done during the year.

The seventeenth part is a summary of the work done during the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22431

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elsie M. Alleger</b>				2. Date of Death Month Day Year <b>June 30 1999</b>				3. Time of Death <b>8:30 A.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Union Hospital</b>				4b. City, Town, or Location of Death <b>Elkton</b>				4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>214-36-6314</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>February 23, 1921</b>		9. Birthplace (State or Foreign Country) <b>Darlington, MD</b>		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>229 Fletchwood Road</b>		10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>own home</b>		17. Father's Name (First, Middle, Last) <b>William F. Crouse</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Dacia E. Caudill Crouse</b>		
19a. Informant's Name/Relationship (Type, Print) <b>John F. Alleger, Sr.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>229 Fletchwood Road, Elkton, MD 21921</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Tabor Cemetery</b>		20c. Location - City or Town, State <b>July 3, 1999 Spring Gap, Maryland</b>		
21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Gee Funeral Home</b>		22. Name and Address of Facility <b>259 E. Main St., Elkton, MD 21921</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Diabetes mellitus type 2</b> <b>Alzheimer's disease</b> <b>Malnutrition</b>		Approximate Interval Between Onset and Death <b>Days</b>		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D45155</b>		
29d. Date signed (Month, Day, Year) <b>June 30, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John R. Mulvey M.D., 111 West High St. Suite 214, Elkton, MD 21921</b>		31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>		32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



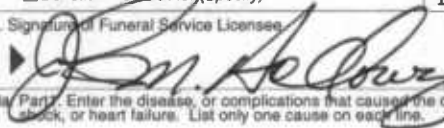
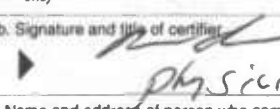
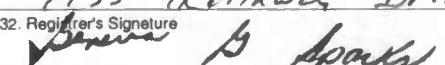
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 22432

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER CLARENCE ANDERSON</b>					2. Date of Death Month Day Year <b>June 27, 1999</b>		3. Time of Death <b>12:45 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>					4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>		
Funeral Director	5. Social Security Number <b>213-24-0724</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>70</b>		8. Date of Birth (Month, Day, Year) <b>July 6, 1928</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>				10d. Inside City Limits <b>1 Yes 2 No</b>		
10e. Street and Number <b>510 N. Pinehurst Ave.</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates: <b>Air Force</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>7</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Lawyer</b>			16b. Kind of Business/Industry <b>Law</b>			
17. Father's Name (First, Middle, Last) <b>Walter C. Anderson</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Davis</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Rosann Anderson/Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>510 N. Pinehurst Ave., Salisbury, MD 21801</b>					
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parsons Cemetery</b>		20c. Date <b>6/30/99</b>		20d. Location - City or Town, State <b>Salisbury, MD</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>					
23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>airway obstruction</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
23b. Part 2: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death <b>4 days</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>			
24a. Was an autopsy performed? <b>1 Yes 2 No</b>							24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>			
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>			26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred	
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>			29b. Signature and title of certifier  <b>Physician</b>			29c. License number <b>444283</b>		29d. Date signed (Month, Day, Year) <b>6/27/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Durkin 9733 Heilbrunn Drive Berlin, MD</b>										
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>			32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Anderson WALTER 213-24-0724 6/27/99 1245.

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

*[Handwritten signature or initials.]*

JOHN S. HULL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22433

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Elijah Bandy

2. Date of Death

June 28 1999

3. Time of Death

2023

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton, MD

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

229-32-6232

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

February 23, 1928

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

118 Osage Street

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Mobile Home Manufacturing

17. Father's Name (First, Middle, Last)

Jiles Bandy

18. Mother's Name (First, Middle, Maiden Surname)

Betty Sparks

19a. Informant's Name/Relationship (Type, Print)

Irene Bandy/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

118 Osage Street, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of cemetery, crematory or other place)  
Gilpin Manor Memorial Park

Date

7/1/99

20c. Location - City or Town, State

Elkton, Maryland

21. Signature of Funeral Service Licensee

Dana S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 West Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

b. chronic alcoholism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

43 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MI, CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephanie Ortega

29c. License number

D0061435

29d. Date signed (Month, Day, Year)

6/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephanie Ortega MD - 100 Bow St, Elkton MD (Union Hosp)

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 1999

32. Registrar's Signature

Stephanie B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22434

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ARDEE AUSTIN BARRETT</b>				2. Date of Death Month Day Year <b>JUNE 30, 1999</b>		3. Time of Death <b>8:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>141 BOND ST., APT. E</b>				4b. City, Town, or Location of Death <b>WESTMINSTER</b>		4c. County of Death <b>CARROLL</b>		
Funeral Director	5. Social Security Number <b>216-16-1475</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 12, 1924</b>		
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD.</b>		10b. County <b>CARROLL</b>		10c. City, Town or Location <b>WESTMINSTER</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>141 BOND ST., APT. E</b>		10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>USA.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>GROCERY MANAGER</b>		16b. Kind of Business/Industry <b>GROCERY STORE</b>		17. Father's Name (First, Middle, Last) <b>ARDEE R. BARRETT</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LOLA ARRINGTON</b>	
19a. Informant's Name/Relationship (Type, Print) <b>DOROTHY WHEELER -SISTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2201 OLD WASHINGTON RD., WESTMINSTER, MD. 21157</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>7/1/99 BALTIMORE, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>FLETCHER FUNERAL HOME</b> <b>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular disease</b> Due to (or as a consequence of): <b>b. disease</b> Due to (or as a consequence of): <b>c. peripheral vascular disease</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>10 years</b> <b>1 year</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D38915</b>		29d. Date signed (Month, Day, Year) <b>7/1/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FREISY 295 Stoner Ave Westminister MD 21157</b>		31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22435

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

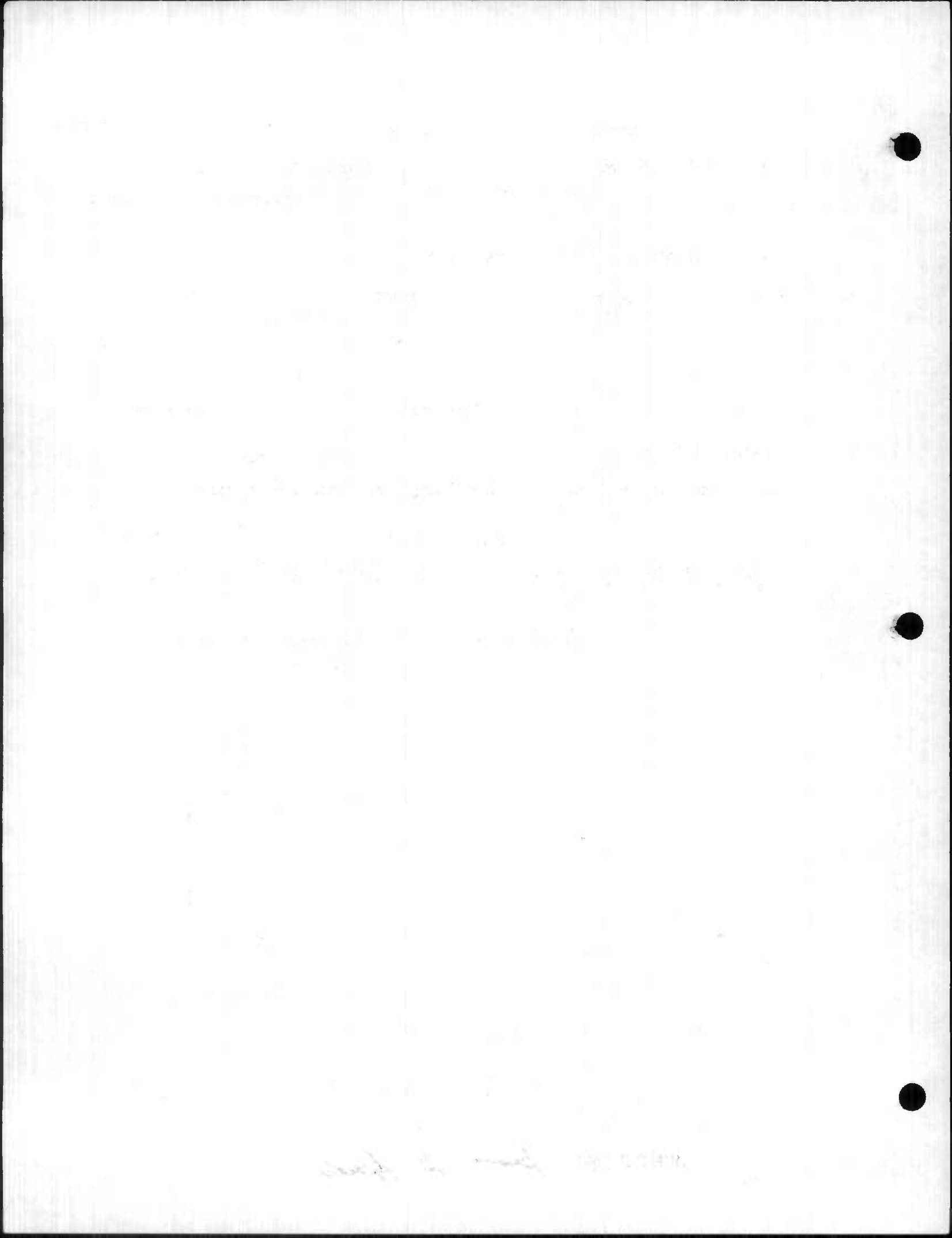
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Anne McCartney Berg</b>		2. Date of Death Month <b>June</b> Day <b>28</b> Year <b>1999</b>		3. Time of Death <b>7.05am</b>
4a. Facility Name (If not institution, give street and number) <b>34666 Railroad Avenue</b>		4b. City, Town, or Location of Death <b>Pittsville</b>		4c. County of Death <b>Wicomico</b>
5. Social Security Number <b>431-24-8914</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>02-16-1925</b>		9. Birthplace (State or Foreign Country) <b>Missouri</b>		
10a. State <b>Maryland</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Pittsville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>34666 Railroad Avenue</b>		10f. Zip Code <b>21850</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Missionary</b>		16b. Kind of Business/Industry <b>Ministry</b>		
17. Father's Name (First, Middle, Last) <b>Edward McCartney</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Maggie Morgan</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Paul A. Berg Sr.-Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>34666 Railroad Avenue, Pittsville, Md 21850</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pittsville Cemetery</b>		20c. Location - City or Town, State <b>6/30/99 Pittsville, MD</b>
21. Signature of Funeral Service Licensee <b>David H. Thompson</b>		22. Name and Address of Facility <b>Holloway Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Md. 21804</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. <b>metastatic hemangiopericytoma</b>				Approximate Interval Between Onset and Death
Due to (or as a consequence of):				
Due to (or as a consequence of):				
Due to (or as a consequence of):				
Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <b>Long H. Dang M.D.</b>		29c. License number <b>RES-9999</b>		29d. Date signed (Month, Day, Year) <b>6/28/99</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>600 N. Wolfe St LONG H. DANG</b>				
31. Date filed (Month, Day, Year) <b>6/28/99</b>		32. Registrar's Signature <b>Sparks</b>		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22436

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Beatrice M. Bunting</b>				2. Date of Death Month <b>June</b> Day <b>27</b> Year <b>1999</b>		3. Time of Death <b>6:45 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>32357 Morris Leonard Road</b>				4b. City, Town, or Location of Death <b>Parsonsborg</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>214-12-5366</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>1-18-1921</b>	
	10a. State <b>Md.</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Parsonsborg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>32357 Morris Leonard Road</b>				10f. Zip Code <b>21849</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>		16b. Kind of Business/Industry <b>Garment Co.</b>		
17. Father's Name (First, Middle, Last) <b>Bennie R. Perdue</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Truitt</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Cynthia J. Lecates, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>709 Jackson St. Salisbury, Md. 21804</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wicomico Memorial Park</b>		20c. Location - City or Town, State <b>Salisbury, Md.</b>		20d. Date <b>6-29-99</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Glioblastoma</b> Due to (or as a consequence of): <b>b. HTN</b> Due to (or as a consequence of): <b>c. DVT</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>D0054127</b>		29d. Date signed (Month, Day, Year) <b>06/28/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alon DAVIS 3 Bistate Blvd Delmar MD 21875</b>								
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

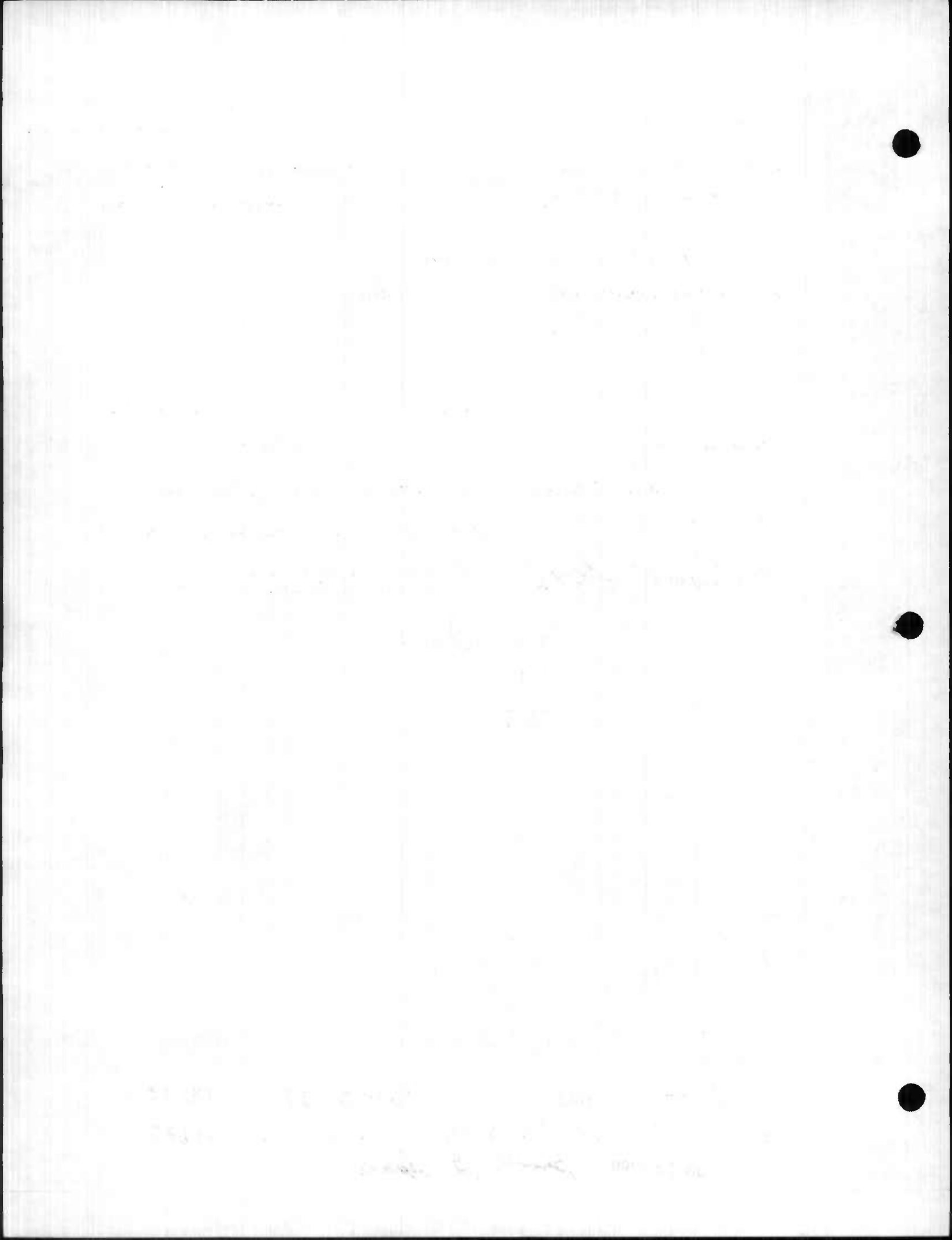
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22437

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wendell Chester Casson</b>				2. Date of Death Month <b>June</b> Day <b>27</b> Year <b>1999</b>		3. Time of Death <b>12:10 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Nursing Home - Spa Creek</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>213-34-6408</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar 12, 1938</b>	
	9. Birthplace (State or Foreign Country) <b>Kentucky</b>							
Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>716 Dividing Road</b>				10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer Engineer</b>			16b. Kind of Business/Industry <b>Mainframe Computers</b>	
17. Father's Name (First, Middle, Last) <b>L. Chester Casson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Blanche Casebolt</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Blanche Casson / mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>716 Dividing Road, Severna Park, MD 21146</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		Date <b>June 30 1999</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park F.H. 495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease condition resulting in death) a. <b>metastatic rectal cancer</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Thomas M. Walsh MD</b>				29c. License number <b>D23867</b>		29d. Date signed (Month, Day, Year) <b>6-29-99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THOMAS M. WALSH MD 277 Peninsula Farm Road Arnold MD 21012</b>								
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



99-3893-003

PATRICK JOSEPH CIERVO

ASP

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G773 7-23-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22438

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patrick Joseph Ciervo</b>				2. Date of Death Month Day Year <b>JULY 06 1999</b>				3. Time of Death <b>2027</b>		
	4a. Facility Name (If not institution, give street and number) <b>22 CHESTNUT HILL AVE</b>				4b. City, Town, or Location of Death <b>SEVERNA PARK</b>				4c. County of Death <b>ANNE ARUNDEL</b>		
Funeral Director	5. Social Security Number <b>212-44-7035</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>52</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 23, 1947</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>74 Robinson Landing Road</b>				10f. Zip Code <b>21146</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steam Fitter</b>				16b. Kind of Business/Industry <b>Pipework</b>			
17. Father's Name (First, Middle, Last) <b>Patrick J. Ciervo, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Betty Errickson</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Betty Collins/mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>74 Robinson Landing Road, Severna Park, MD 21146</b>							
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery</b>		Date performed <b>July 10 1999</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>					
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home</b> <b>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. NARCOTIC INTOXICATION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found 7-6-99</b>		28b. Time of Injury <b>8:30 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SUBJECT INGESTED DRUGS</b>			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND AT HOME</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>22 CHESTNUT HILL, SEVERNA PARK, MARYLAND</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>O.C.M.E</b>				29d. Date signed (Month, Day, Year) <b>JULY 07, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>											
State Registrar		31. Date filed (Month, Day, Year) <b>JUL 09 1999</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22439

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Opal Marie Copeland</b>				2. Date of Death Month Day Year <b>June 28, 1999</b>		3. Time of Death <b>5:45 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sunrise Assisted Living</b>				4b. City, Town, or Location of Death <b>Severna Park</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>208-18-8766</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan 16, 1913</b>		9. Birthplace (State or Foreign Country) <b>PA</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Arnold</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>703 White Swan Drive</b>				10f. Zip Code <b>21012</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Home</b>		
17. Father's Name (First, Middle, Last) <b>Lewis A. Lehman</b>				18. Mother's Name (First, Middle, Maiden Sumame) <b>Clara Trout</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Kathie L. Shay/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>703 White Swan Drive, Arnold, MD 21012</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fairview Cemetery of Shillington, Inc.</b>			Date <b>July 1 1999</b>		20c. Location - City or Town, State <b>Shillington, PA</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive heart failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>diabetes</b> <b>cerebrovascular accident</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ASSISTED LIVING</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>LIVING</b>	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>Thomas M. Walsh MD</b>				29c. License number <b>D23867</b>		29d. Date signed (Month, Day, Year) <b>6-28-99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THOMAS WALSH MD, 277 Peninsula Farm Road, ARNOLD MD 21012</b>									
31. Date filed (Month, Day, Year) <b>JUN 30 1999</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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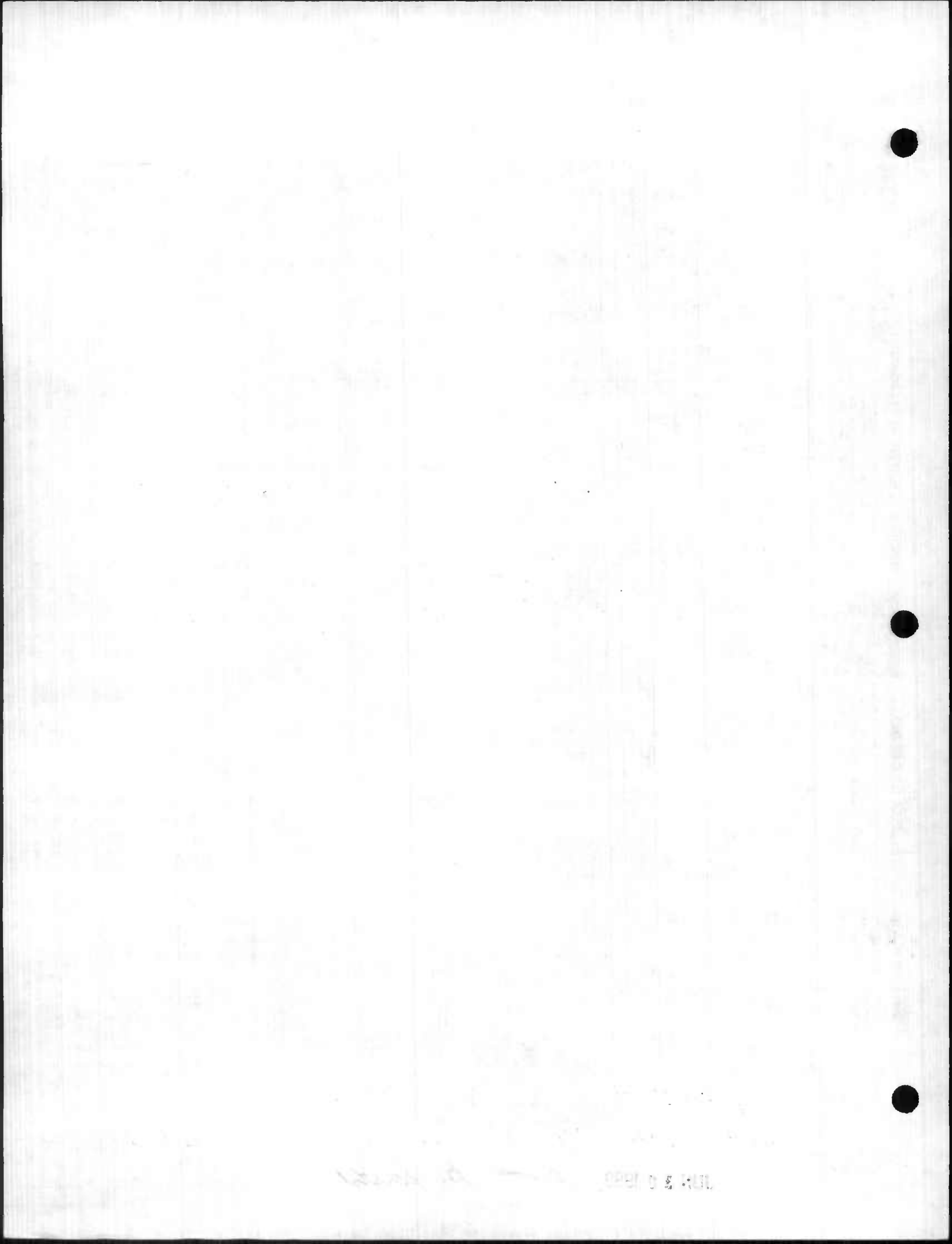
To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

ORIGINAL



10/10/10

10/10/10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22440

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WOODROW WILSON CANTWELL</b>				2. Date of Death Month: <b>06</b> Day: <b>28</b> Year: <b>99</b>		3. Time of Death <b>1820</b>	
	4a. Facility Name (If not institution, give street and number) <b>1008 PIERCE AVENUE</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>214-16-4221</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02-17-13</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1008 Pierce Ave.</b>		10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>9</b> College (1-4 or 5+): <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mason</b>		16b. Kind of Business/Industry <b>Brick/Construction</b>				
17. Father's Name (First, Middle, Last) <b>Roland Thomas Cantwell Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sally Jane Taylor</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Michael H. Cantwell/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6278 Westbrooke Dr., Salisbury, MD 21801</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parsons Cemetery</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>		20d. Date <b>7/1/99</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association</b> <b>501 Snow Hill Rd., Salisbury, MD 21804</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>DME</b>				29c. License number <b>D0003599</b>		29d. Date signed (Month, Day, Year) <b>6-29-99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN T. BULKELEY, M.D. 108 PINE BLUFF ROAD SALISBURY, MD. 21801</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22441

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Marian D Dick</b>				2. Date of Death Month <b>June</b> Day <b>29</b> Year <b>1999</b>				3. Time of Death <b>7:00 pm</b>			
4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>				4c. County of Death <b>Anne Arundel</b>			
5. Social Security Number <b>222-03-0076</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>80</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>Nov. 5, 1918</b>	
9. Birthplace (State or Foreign Country) <b>Deleware</b>											
Usual Residence of Decedent											
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Riva</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>3067 Riverview Rd.</b>				10f. Zip Code <b>21140</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>				16b. Kind of Business/Industry <b>Administration</b>			
17. Father's Name (First, Middle, Last) <b>Martin D. Dick</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha Clayville</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Gregory P. Dick / Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3067 Riverview Rd. Riva, Md. 21140</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory</b>				Date <b>7/1/99</b>		20c. Location - City or Town, State <b>Brentwood, Md.</b>	
21. Signature of Funeral Service Licensee <b>W. Halland</b>						22. Name and Address of Facility <b>John M. Taylor Funeral Home Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. head injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>06/29/99</b>		28b. Time of Injury <b>4:00 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>CAR ACCIDENT</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>CAR</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>ANNA POLIS, MD</b>									
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>Jeffrey Buggs MD</b>						29c. License number <b>D28640</b>			29d. Date signed (Month, Day, Year) <b>June 29, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>2414 Hightee Ct. Crofton MD 21114</b>											
31. Date filed (Month, Day, Year) <b>JUL 6 1 1999</b>				32. Registrar's Signature <b>B. Sparks</b>							

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22442

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANKLYN THEODORE DUNN</b>			2. Date of Death Month Day Year <b>JUNE 29, 1999</b>			3. Time of Death <b>11:34 PM.</b>				
	4a. Facility Name (If not institution, give street and number) <b>LONG VIEW NURSING HOME</b>			4b. City, Town, or Location of Death <b>MANCHESTER</b>			4c. County of Death <b>CARROLL</b>				
Funeral Director	5. Social Security Number <b>145-03-6589</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/6/1910</b>		9. Birthplace (State or Foreign Country) <b>NEW JERSEY</b>		
	Usual Residence of Decedent			10c. City, Town or Location <b>STANHOPE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10a. State <b>NEW JERSEY</b>			10b. County <b>SUSSEX</b>			10e. Street and Number <b>53 RICHMOND RD.</b>			10f. Zip Code <b>07874</b>		
10g. Citizen of What Country? <b>USA.</b>			11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INSURANCE INVESTIGATOR</b>			16b. Kind of Business/Industry <b>INSURANCE</b>		
17. Father's Name (First, Middle, Last) <b>FREDERICK DUNN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>FLORENCE CUMMINGS</b>			19a. Informant's Name/Relationship (Type, Print) <b>HELEN STRASKULIC -DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 KALTEN RD., WESTMINSTER, MD. 21158</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GATE OF HEAVEN CEM.</b>			20c. Date <b>7/6/99</b>			20d. Location - City or Town, State <b>EAST HANOVER, N.J.</b>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>FLETCHER FUNERAL HOME</b> <b>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Myocardial infarction</b> Due to (or as a consequence of) b. <b>ASCVD</b> Due to (or as a consequence of) c. <b>atherosclerosis</b> Due to (or as a consequence of) d.			Approximate Interval Between Onset and Death <b>2 wk</b> <b>10 yrs</b> <b>4 yrs</b>		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury <b>M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>D25443</b>			29d. Date signed (Month, Day, Year) <b>6.30.99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Middleton</b> <b>688 Poole Road, Westminster MD 21157</b>			31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>			32. Registrar's Signature 			State Registrar		

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1215 EAST 58TH STREET  
CHICAGO, ILL. 60637  
TEL. 733-4331

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CHICAGO, ILL. 60637  
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TEL. 733-4331

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CHICAGO, ILL. 60637  
TEL. 733-4331



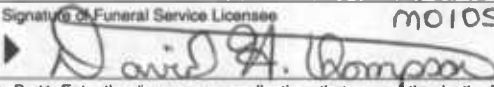
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22443

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Steven Vincent Downing</b>				2. Date of Death Month Day Year <b>June 25, 1999</b>		3. Time of Death <b>6:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center: Genesis ElderCare</b>				4b. City, Town, or Location of Death <b>Salisbury, MD</b>		4c. County of Death <b>Wicomico</b>		
Funeral Director	5. Social Security Number <b>213-44-0126</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>53</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 15, 1945</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>722 Edgar Dr.</b>		10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Robt. Messick Construction</b>		17. Father's Name (First, Middle, Last) <b>Paul Vincent Downing</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Eloise Cutright</b>	
19a. Informant's Name/Relationship (Type, Print) <b>LaDonna A. McKee/Friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>722 Edgar Dr., Salisbury, MD 21804</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association</b> <b>501 Snow Hill Rd., Salisbury, MD 21804</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. GASTRIC ADENOCARCINOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. c. d.</b> Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>Months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 39813</b>		29d. Date signed (Month, Day, Year) <b>6/25/99</b>			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804</b>		31. Data filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22444

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PEARL ELLIOTT				2. Date of Death Month Day Year JUNE 29 1999		3. Time of Death 3:45 PM																																																										
	4a. Facility Name (If not institution, give street and number) 809 JOHNSON ST.				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO																																																										
Funeral Director	5. Social Security Number 214-10-8041		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT 1, 1914	9. Birthplace (State or Foreign Country) MARYLAND																																																									
	Usual Residence of Decedent																																																																
10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location FRUITLAND			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																										
10e. Street and Number 105 SPRUCE ST.				10f. Zip Code 21826		10g. Citizen of What Country? U. S. A.																																																											
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																																																										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS		16b. Kind of Business/Industry SHIRT FACTORY																																																											
17. Father's Name (First, Middle, Last) JOHN WILLIAM MORRIS					18. Mother's Name (First, Middle, Maiden Surname) MAE SHOCKLEY																																																												
19a. Informant's Name/Relationship (Type, Print) LYNNETTE OWENS -GRANDDAUGHTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 JOHNSON ST. SALISBURY, MD 21804																																																												
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) WICOMICO MEMORIAL PARK		Date 7/2/99		20c. Location - City or Town, State SALISBURY, MARYLAND																																																										
21. Signature of Funeral Service Licensee <i>Robert W. Harris Jr.</i>					22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 705 E. MAIN ST.																																																												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																																	
<table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last             </td> <td>a.</td> <td colspan="6">carcinoma of cervix</td> <td rowspan="4">                 Approximate Interval Between Onset and Death 6 months             </td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="6"></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="6"></td> <td></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td colspan="6"></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	carcinoma of cervix						Approximate Interval Between Onset and Death 6 months	Due to (or as a consequence of):								b.							Due to (or as a consequence of):								c.								Due to (or as a consequence of):									d.							
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	carcinoma of cervix						Approximate Interval Between Onset and Death 6 months																																																									
	Due to (or as a consequence of):																																																																
	b.																																																																
	Due to (or as a consequence of):																																																																
c.																																																																	
Due to (or as a consequence of):																																																																	
d.																																																																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. coronary artery disease adult onset diabetes mellitus							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																																										
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																																										
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																																														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																										
			28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																																																										
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																																																														
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																																																	
29b. Signature and title of certifier <i>Charles B. Silvia Jr</i>					29c. License number D30853		29d. Date signed (Month, Day, Year) 6/30/99																																																										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles B. Silvia Jr MD 100 Power St. Salisbury MD 21804																																																																	
31. Date filed (Month, Day, Year) JUL 01 1999			32. Registrar's Signature <i>James B. Sparks</i>																																																														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

August 18, 1952

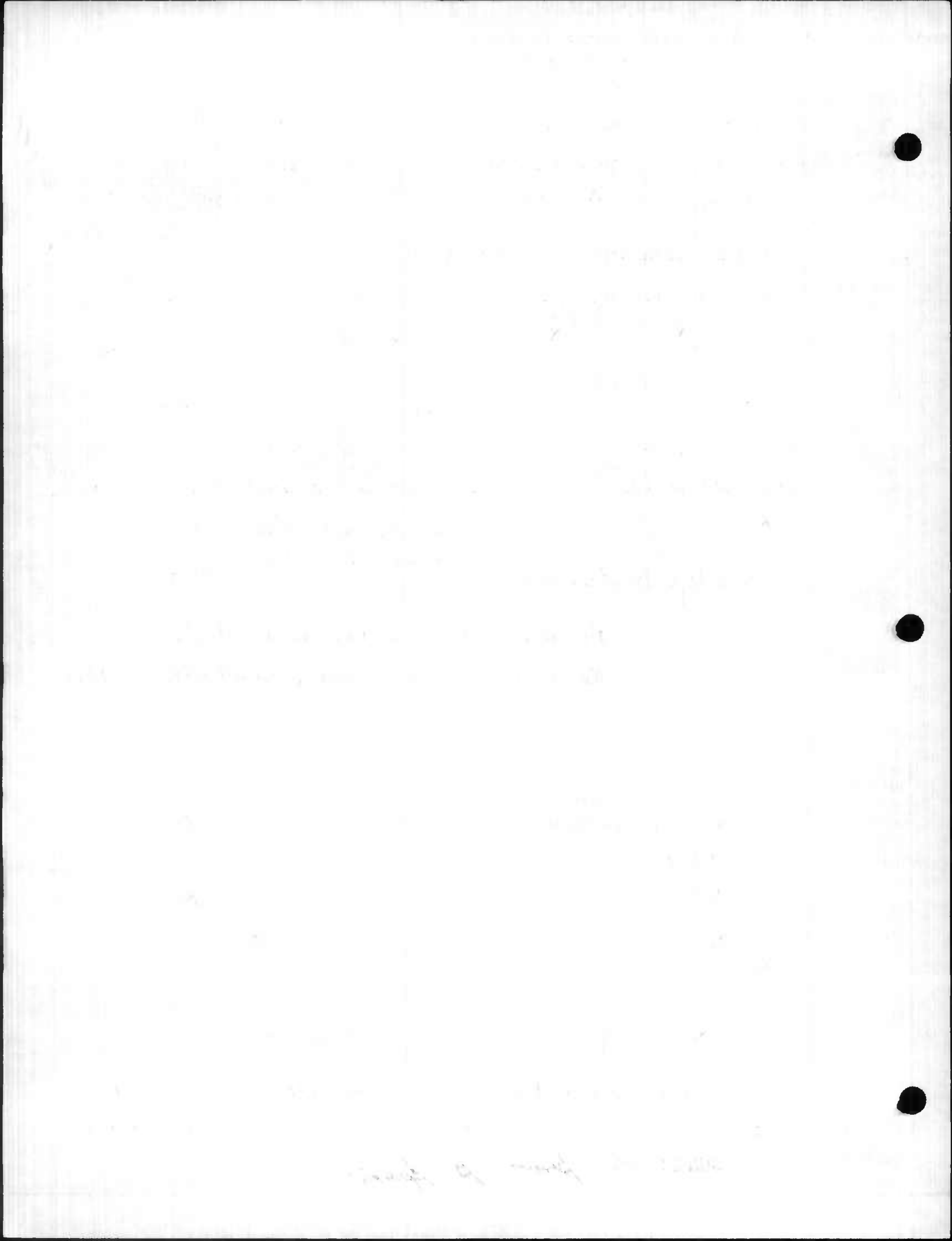
Handwritten signature and date: SEP 10 1952

### Certificate of Death

Reg. No.

99 22445

**Division of Vital Records, P.O. Box 68760,**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #5, per F.D., 7/8/99 Carroll Co., cew

Certificate of Death

Reg. No.

99 22446

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDITH Mae Green</b>				2. Date of Death Month Day Year <b>July 1, 1999</b>		3. Time of Death <b>8:55 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>217-204-1207</b> <b>217-14-4207</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 7, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Carroll</b> 10c. City, Town or Location <b>Hampstead</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Street and Number <b>4120 Hillcrest Avenue</b>		12. Zip Code <b>21074</b>	
13. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		14. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		15. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		16. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> Collage (14 or 5+) <b>Collage</b>		18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		19. Kind of Business/Industry <b>Own Home</b>		20. Father's Name (First, Middle, Last) <b>Harry Edwin Reed</b>		
21. Mother's Name (First, Middle, Maiden Surname) <b>Emma Effie Lippy</b>		22. Informant's Name/Relationship (Type, Print) <b>Raymond Green, husband</b>		23. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4120 Hillcrest Ave, Hampstead, Md 21074</b>		24. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
25. Place of Disposition (Name of cemetery, crematory or other place) <b>Snydersburg Cemetery</b>		26. Date <b>7/6</b>		27. Location - City or Town, State <b>Hampstead, MD</b>		28. Signature of Funeral Service Licensee <b>Steven W Eline</b>		
29. Name and Address of Facility <b>Eline Funeral Home</b> <b>934 South Main St, Hampstead, MD 21074</b>		30. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Septic shock</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Chronic Renal failure</b>		31. Approximate Interval Between Onset and Death <b>2 days</b>		32. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal failure</b>		
33. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		34. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		35. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		36. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
37. Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		38. Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		39. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		40. Date of Injury (Month, Day, Year)		
41. Time of Injury		42. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		43. Describe how injury occurred		44. Location (Street and Number or Rural Route Number, City or Town, State)		
45. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)		46. Location (Street and Number or Rural Route Number, City or Town, State)		47. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		48. Signature and title of certifier <b>M. Nasir MD</b>		
49. License number <b>D35711</b>		50. Date signed (Month, Day, Year) <b>7/01/99</b>		51. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mokhtar Nasir 904 Washington Rd Suite D Westminster, MD 21157</b>		52. Data filed (Month, Day, Year) <b>JUL 02 1999</b>		
53. Registrar's Signature <b>B. Sparks</b>		54. State Registrar		55. State Registrar		56. State Registrar		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22447

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roland James Griffin</b>				2. Date of Death Month Day Year <b>June 27, 1999</b>		3. Time of Death <b>4:45 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>570 S. Houcksville Road</b>				4b. City, Town, or Location of Death <b>Hampstead</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>216-18-3994</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 14, 1923</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Hampstead</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>570 S. Houcksville Road</b>		10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>General Mechanical Foreman</b>		16b. Kind of Business/Industry <b>Bethlehem Steel</b>			
	17. Father's Name (First, Middle, Last) <b>Harry Griffin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Dvorak</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Matilda Griffin, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>570 S. Houcksville Rd, Hampstead, Md 21074</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		Date <b>6/30</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <b>Huey W. Elane</b>				22. Name and Address of Facility <b>Eline Funeral Home 934 South Main St, Hampstead, MD 21074</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>PROLYMPHOCTIC LEUKEMIA</b> Due to (or as a consequence of): <b>CHRONIC LYMPHOCTIC LEUKEMIA</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death <b>9 yrs</b> <b>2 yrs</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Flavio Kruder M.D.</b>		29c. License number <b>D35398</b>		29d. Date signed (Month, Day, Year) <b>6-28-99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Flavio Kruder, M.D. 224 Washington Heights, Westminster, MD 21074</b>								
31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>		32. Registrar's Signature <b>Beverly B. Sparks</b>						

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22448

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS LOUETTA GILROY

2. Date of Death  
Month Day Year  
JUNE 28 1999  
3. Time of Death  
6:52 PM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

210-03-2227

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

OCT. 25, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 MAIDEN CHOICE LANE, APT. CC601

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

FREDERICK B.

WIPPERT

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA

UHL

19a. Informant's Name/Relationship (Type, Print)

WILLIAM R. GILROY (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
715 MAIDEN CHOICE LANE, APT. CC601, CATONSVILLE, MD. 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION CENTER LLC, STEVENSVILLE, MD.

Date  
6/30/99

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, P.A.,  
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. HIP SURGERY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

36 MINUTES

2 Hr 9 mins

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC BREAST CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wm C WATERFIELD MD

29c. License number

024356

29d. Date signed (Month, Day, Year)

June 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wm C WATERFIELD MD

St Agnes Health Care  
900 Calver Ave Balt Md 21229

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

B. Spade

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: Doris L. Gilroy  
Division of Vital Records, P.O. Box 68760,

*[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]*

*[Handwritten signature or initials.]*

JUL 2 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22449

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE BENJAMIN GRIFFIN SR.</b>						2. Date of Death Month Day Year <b>June 27, 1999</b>		3. Time of Death <b>10:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>32061 Old Ocean City Rd.</b>						4b. City, Town, or Location of Death <b>Parsonsbury</b>		4c. County of Death <b>Wicomico</b>		
Funeral Director	5. Social Security Number <b>218-34-7512</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Parsonsbury</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>32061 Old Ocean City Rd.</b>		10f. Zip Code <b>21849</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Feed Mill Operator</b>		16b. Kind of Business/Industry <b>Poultry</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		17. Father's Name (First, Middle, Last) <b>Henry Monroe Griffin Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Erma Donoway</b>	
19a. Informant's Name/Relationship (Type, Print) <b>George B. Griffin Jr./Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>32081 Old Ocean City Rd., Parsonsbury, MD 21849</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverside Cemetery</b>		Date <b>6/30/99</b>		20c. Location - City or Town, State <b>Libertytown, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Colon Cancer</b>		Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>2 yrs</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> <b>c.</b> <b>d.</b>		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D26278</b>		29d. Date signed (Month, Day, Year) <b>6-28-99</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Carroll, MD 175 E. Carroll St. Salisbury, MD 21801</b>		31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar

1032



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22450

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) Acie Hoover Hamilton				2. Date of Death Month: July 1 Day: 1999		3. Time of Death 0828	
4a. Facility Name (If not institution, give street and number) Residence: 8 Pleasant View Church Road				4b. City, Town, or Location of Death Port Deposit		4c. County of Death Cecil	
5. Social Security Number 230-34-9874		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 26, 1930	
9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Port Deposit	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8 Pleasant View Church Road		10f. Zip Code 21904		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-53		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Two Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry U.S. Army			
17. Father's Name (First, Middle, Last) Johnney Monroe Hamilton				18. Mother's Name (First, Middle, Maiden Summa) Virginia Ellen Mays			
19a. Informant's Name/Relationship (Type, Print) Michael D. Hamilton (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Pleasant View Church Road, Port Deposit, Maryland 21904			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mark's Cemetery		Data 7/7/99		20c. Location - City or Town, State Perryville, Maryland	
21. Signature of Funeral Service Licensee <i>Thomas M. Patterson, Sr.</i>				22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Throat Cancer</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death <i>months</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Jeffrey M. Thompson</i>				29c. License number D0053309		29d. Date signed (Month, Day, Year) 07/01/1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Jeffrey M. Thompson</i> 106 Bow St., Elkton, Maryland 21921							
31. Date filed (Month, Day, Year) JUL 06 1999				32. Registrar's Signature <i>Benjamin B. Sparks</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22451

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HENRIC TIA HENSON

2. Date of Death

6 29 99

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

100 Beech DRIVE

4b. City, Town, or Location of Death

ELKTON

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

218-28-2524

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10 8 1912

9. Birthplace (State or Foreign Country)

Cecil

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

ELKTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

100 Beech DRIVE

10f. Zip Code

21921

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MAID

16b. Kind of Business/Industry

PRIVATE Homes

17. Father's Name (First, Middle, Last)

William Henson

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE HOLLINGSWORTH

19a. Informant's Name/Relationship (Type, Print)

ANN B. MURRAY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

100 Beech DRIVE - ELKTON, MD 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BOHEMIA MANOR CTY.

Date

7/3/99

20c. Location - City or Town, State

Chesapeake City, MD

21. Signature of Funeral Service Licenses

[Signature]

22. Name and Address of Facility

Wilm. DE 19805  
Congo Funeral Home - 201 N. GRAY AVE.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

2 1/2 mths

Due to (or as a consequence of):

b. Aspiration Pneumonia possible

3-4 days

Due to (or as a consequence of):

c. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 22307

29d. Date signed (Month, Day, Year)

JUL 7/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

123 SINGERLY AVE, ELKTON, MD 21921

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22652

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR SMITH HYDE

2. Date of Death

Month Day Year  
June 29, 1999

3. Time of Death

2:15am

4a. Facility Name (If not institution, give street and number)

33340 Galena-Sassafras Rd.

4b. City, Town, or Location of Death

Galena

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

148-07-5666

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 20 1918

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Kent

10c. City, Town or Location

Galena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

33340 Galena-Sassafras Rd.

10f. Zip Code

21635

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: -1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Owner-Operator

16b. Kind of Business/Industry

Plastic  
Manufacturer

17. Father's Name (First, Middle, Last)

Arthur L. Hyde

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Smith

19a. Informant's Name/Relationship (Type, Print)

Ruth Hyde (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33340 Galena-Sassafras Rd. Galena MD 21635

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Capitol Crematory

Date

6/29/99

20c. Location - City or Town, State

Dover, DE.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Galena Funeral Home of Stephen Schaeck  
118 West Cross St. Galena, MD. 2163523a. Enter the disease, or combination of diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. *Cardio pulmonary Arrest*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. *Respiratory Failure*  
Due to (or as a consequence of):c. *Constrictive Heart Failure*  
Due to (or as a consequence of):

d. \_\_\_\_\_

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Myelodysplasia, Anemia, Neurodegeneration  
Recurrent pneumonia, History of Left  
Upper Lobe Carcinoma*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

None

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s)  
end manner stated.

29b. Signature and title of certifier

29c. License number

D23889

29d. Date signed (Month, Day, Year)

6/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John C. ARNOLD JR. MD 948 Washington Ave, Chestertown, Del 21620

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 01 1999

Barbara B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "of" are visible.

*[Handwritten signature]*

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "of" are visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "of" are visible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22453

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard Virgis Hayes				2. Date of Death Month Day Year June 30 1999		3. Time of Death 1105	
	4a. Facility Name (If not institution, give street and number) Union Hospital of Cecil County				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 218-26-8824		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 22, 1928	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Cecil		10c. City, Town or Location North East	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 16 Deepwood Lane		10f. Zip Code 21901		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Six Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry James Julian, Inc. Wilmington, Delaware		17. Father's Name (First, Middle, Last) Russ Hayes	
	18. Mother's Name (First, Middle, Maiden Surname) Nina Blevins		19a. Informant's Name/Relationship (Type, Print) Betty R. Taylor (sister)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Deepwood Lane, North East, Maryland 21901		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Darlington Cemetery		20c. Location - City or Town, State Darlington, Maryland		21. Signature of Funeral Service Licensee Thomas M. Patterson Sr.		22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Larynx. Due to (or as a consequence of): b. Pneumonia. Due to (or as a consequence of): c. COPD Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1Y		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Jui Chih Hsu MD		29c. License number D04023	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 7/1/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUI CHIH HSU MD 223 West main st, Elkton MD 21921		31. Date filed (Month, Day, Year) JUL 01 1999		32. Registrar's Signature James B. Sparks	
	33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.		36. To Be Completed by Physician/Medical Examiner	





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 29d, Per Phy.  
7/1/99, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

99 22454

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John William Hagert</b>				2. Date of Death Month Day Year <b>June 28, 1999</b>		3. Time of Death <b>11:35 pm</b>										
	4a. Facility Name (If not institution, give street and number) <b>Westminster Nursing &amp; Rehabilitative Ctr</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>										
Funeral Director	5. Social Security Number <b>215-07-8848</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept 27, 1912</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>									
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	10e. Street and Number <b>17 Ridgeview Drive</b>				10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>USA</b>										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Drill Press Operator</b>			16b. Kind of Business/Industry <b>Western Electric</b>											
	17. Father's Name (First, Middle, Last) <b>George Hagert</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Prechtel</b>												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Catherine Hagert, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17 Ridgeview Dr, Westminster, Md 21157</b>												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		Date <b>7/2</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>										
	21. Signature of Funeral Service Licensee <b>Shirley W. Elmer</b>				22. Name and Address of Facility <b>Eline Funeral Home 934 South Main St, Hampstead, MD 21074</b>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>End Stage COPD</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>10 yrs</b>   <b>4 wks</b>   <b>20 yrs</b> </td> </tr> <tr> <td>b.</td> <td><b>Gangrene Foot</b></td> </tr> <tr> <td>c.</td> <td><b>ASCD</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>End Stage COPD</b>	Approximate Interval Between Onset and Death  <b>10 yrs</b>  <b>4 wks</b>  <b>20 yrs</b>	b.	<b>Gangrene Foot</b>	c.	<b>ASCD</b>	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>End Stage COPD</b>	Approximate Interval Between Onset and Death  <b>10 yrs</b>  <b>4 wks</b>  <b>20 yrs</b>														
	b.	<b>Gangrene Foot</b>															
	c.	<b>ASCD</b>															
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
		28d. Describe how injury occurred				28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)											
		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <b>John W. Middleton</b>				29c. License number <b>D25443</b>		29d. Date signed (Month, Day, Year) <b>June 28, 1999</b>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John W. Middleton, M.D. 688 Poole Road Westminster Md 21157</b>																	
31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>		32. Registrar's Signature <b>Beverly B. Sparks</b>															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22455

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JANET M. HITE</b>						2. Date of Death Month Day Year <b>JUNE 26 1999</b>		3. Time of Death <b>0458</b>		
	4a. Facility Name (If not Institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>						4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>		
Funeral Director	5. Social Security Number <b>202-05-1053</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAR. 9, 1915</b>		9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		
	Usual Residence of Decedent										
10e. State <b>DELAWARE</b>		10b. County <b>NEW CASTLE</b>		10c. City, Town or Location <b>NEWARK</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number <b>2 BISBEE ROAD, RED MILL FARMS</b>						10f. Zip Code <b>19711</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>OWN HOME</b>				
17. Father's Name (First, Middle, Last) <b>HARRY S. JONES</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>EDITH THOMAS</b>					
19a. Informant's Name/Relationship (Type, Print) <b>SHARON HOFFECKER/DAUGHTER</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>875 PORT PENN RD., MIDDLETOWN, DELAWARE 19709</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CAPITOL CREMATORY</b>		Date <b>6/28/99</b>		20c. Location - City or Town, State <b>DOVER, DELAWARE</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>					
23e. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): b. <b>CORONARY HEART DISEASE</b> Due to (or as a consequence of): c. <b>ACUTE RENAL FAILURE</b> Due to (or as a consequence of): d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number <b>046257</b>		29d. Date signed (Month, Day, Year) <b>6/26/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>9714 Heathaway Drive Berlin, MD 21811</b>											
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6/26/99 0458  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar

OFFICE OF THE DIRECTOR

June 1, 1964

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

THOMAS J. [Illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22456

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NORMAN V. JARVIS JR.</b>				2. Date of Death Month <b>June</b> Day <b>28</b> Year <b>1999</b>		3. Time of Death <b>0704</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>221-18-3571</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 20, 1931</b>	9. Birthplace (State or Foreign Country) <b>NEW JERSEY</b>
	Usual Residence of Decedent							
10a. State <b>DELAWARE</b>		10b. County <b>SUSSEX</b>		10c. City, Town or Location <b>FENWICK ISLAND</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>10 WEST GEORGETOWN STREET</b>				10f. Zip Code <b>19944</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PURCHASING AGENT</b>			16b. Kind of Business/Industry <b>AGRICULTURE</b>	
17. Father's Name (First, Middle, Last) <b>NORMAN V. JARVIS SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MAUDE TINGLE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>BONNIE L. JARVIS/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 WEST GEORGETOWN ST., FENWICK ISLAND, DE 19944</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ROXANA CEMETERY</b>		Date <b>7/1/99</b>		20c. Location - City or Town, State <b>ROXANA, DELAWARE</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>				
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death. <b>Massive Cerebral Hemorrhage</b>						Approximate Interval Between Onset and Death <b>7 Hour</b>	
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death. <b>Ischemic Demencia</b> <b>Coronary artery disease</b>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and Title of certifier 		29c. License number <b>D19432</b>		29d. Date signed (Month, Day, Year) <b>6/28/99</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>J. L. Davis 560 Riverside Dr AWO2 Salisbury, MD</b>								
31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

GOOT & S. MUL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22457

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN KENNETH

JURNEY, SR.

2. Date of Death  
Month Day Year  
JULY 1, 1999

3. Time of Death  
4:26 A.M.

4a. Facility Name (If not institution, give street and number)

GENESIS ELDER CARE

4b. City, Town, or Location of Death

SEVERNA PARK

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

215-24-9165

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

FEB. 3, 1930

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

LINTHICUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

421 JEROME AVENUE

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1948-

If Yes, Give Year or Dates: 1951

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PLUMBER

16b. Kind of Business/Industry

PLUMBER'S UNION

17. Father's Name (First, Middle, Last)

SPENCER

H.

JURNEY

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET

KLINE

19a. Informant's Name/Relationship (Type, Print)

MARY JURNEY

(WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

421 JEROME AVENUE, LINTHICUM, MARYLAND 21090

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK

Date

7/6/1999

20c. Location - City or Town, State

ELKBRIDGE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, P.A.,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Probable Cerebrovascular Accident

Due to (or as a consequence of):

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

72 years

c. Diabetes Mellitus - Type II

Due to (or as a consequence of):

72 years

d. Coronary Artery Disease

72 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John F. Leone, M.D.

29c. License number

D52728

29d. Date signed (Month, Day, Year)

7/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. Leone, M.D. 479 Jumpers Hole Rd, Suite 304 Severna Park, MD 21146

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

B. Arndt

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



JUL 5 1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 22458

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BURCHELL</b>				2. Date of Death Month <b>JUNE</b> Day <b>25</b> Year <b>1999</b>				3. Time of Death <b>16:11 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>JOHN'S HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>				4c. County of Death		
Funeral Director	5. Social Security Number <b>213-55-8220</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>2</b> Months <b>2</b> Days <b>2</b>		8. Date of Birth (Month, Day, Year) <b>Apr. 23 1999</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>901 Price Road</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>U.S.A</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) <b>Burchell Jones</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Kimberly Bishop</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Kimberly Bishop (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>901 Price Road Salisbury, Md. 21801</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Mem. Garden</b>				20c. Location - City or Town, State <b>Hebron, Md.</b>		20d. Date <b>6/30/99</b>	
21. Signature of Funeral Service Licensee <b>Gladys B. Stewart</b>				22. Name and Address of Facility <b>Stewart Funeral Home</b> <b>821 West Rd. Salisbury, Md. 21801</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ADULT RESPIRATORY DISTRESS SYNDROME</b> Due to (or as a consequence of): <b>b. PNEUMOTHORAX</b> Due to (or as a consequence of): <b>c. ENDOCARDITIS</b> Due to (or as a consequence of): <b>d. PREMATUREITY</b>								Approximate Interval Between Onset and Death <b>16 Days</b> <b>16 Days</b> <b>41 Days</b> <b>63 Days</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>D. McWilliams M.D.</b>				29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>JUNE 26 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DEBORAH McWILLIAMS 600 N WOLFE ST BALTIMORE MD 21287</b>				31. Date filed (Month, Day, Year) <b>JUN 29 1999</b>				32. Registrar's Signature <b>B. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22459

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Carroll Ellsworth Kelbaugh</b>				2. Date of Death Month Day Year <b>June 27, 1999</b>				3. Time of Death <b>0400</b>	
4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>				4b. City, Town, or Location of Death <b>Westminster</b>				4c. County of Death <b>Carroll</b>	
5. Social Security Number <b>213-01-4274</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar 3, 1912</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Hampstead</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. Street and Number <b>3825 Shiloh Avenue Apt 4</b>				10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4or 5+)</b> <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Minister</b>				16b. Kind of Business/Industry <b>United Methodist Church</b>	
17. Father's Name (First, Middle, Last) <b>Herman L. Kelbaugh</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Kirby</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mildred Kelbaugh, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3825 Shiloh Ave, apt 4, Hampstead, MD 21074</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pleasant Grove Cemetery</b>		Date <b>6/30</b>		20c. Location - City or Town, State <b>Reisterstown, MD</b>	
21. Signature of Funeral Service Licensee <i>Staves W Eline</i>				22. Name and Address of Facility <b>Eline Funeral Home</b> <b>934 South Main St, Hampstead, Md 21074</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Coronary Artery Disease</b> Due to (or as a consequence of):  f. <b>Diabetes Mellitus</b> Due to (or as a consequence of):  g. Due to (or as a consequence of):  h. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 Day</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's Disease.</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Rebecca Goedeker MD</i>				29c. License number <b>040223</b>	
				29d. Date signed (Month, Day, Year) <b>6/28/99</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Rebecca Goedeker MD 4231 Northwoods Trail Hampstead, MD 21074</b>									
31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>				32. Registrar's Signature <i>Benjamin B. Sparks</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-588-0058.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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BRUCE D. LEDFORD

ASP

AMEND ITEMS: #23 PART I, 27 PER MEO G773 7-29-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22460

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Bruce Ledford				2. Date of Death Month Day Year JULY 06 1999		3. Time of Death 2215	
	4a. Facility Name (If not institution, give street and number) 4492 BAPTIST RD.				4b. City, Town, or Location of Death TANEYTOWN		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 213-82-6468		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 8, 1961	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Taneytown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4492 Baptist Rd.		10f. Zip Code 21787		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1979-82		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction		17. Father's Name (First, Middle, Last) David A. Ledford	
	18. Mother's Name (First, Middle, Maiden Surname) Phyllis C. Engel		19a. Informant's Name/Relationship (Type, Print) Phyllis C. Ledford/mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14813 Black Ankle Rd, Mt. Airy, Md. 21771		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Locust Grove Cemetery		20c. Location - City or Town, State 7/10/99 Mt. Airy, Md.		21. Signature of Funeral Service Licensee <i>Catherine O. Hartzler</i>		22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, Md.	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DILATED CARDIOMYOPATHY a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>		29c. License number O.C.M.E	
	29d. Date signed (Month, Day, Year) JULY 07, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201		31. Data filed (Month, Day, Year) JUL 12 1999		32. Registrar's Signature <i>Benita B. Sparks</i>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22461

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ellen Dowling Meekins				2. Date of Death Month Day Year July 1, 1999		3. Time of Death 10:00 pm		
	4a. Facility Name (If not institution, give street and number) 3810 Sunnyfield Court				4b. City, Town, or Location of Death Hampstead		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 083-14-3256		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 15, 1911	9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Hampstead			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3810 Sunnyfield Court				10f. Zip Code 21074		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Commercial Credit			
17. Father's Name (First, Middle, Last) John Dowling				18. Mother's Name (First, Middle, Maiden Surname) Annie Hugo					
19a. Informant's Name/Relationship (Type, Print) Nicholas Meekins, husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Sunnyfield Ct, Hampstead, MD 21074					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremations		Date 7/3		20c. Location - City or Town, State Hampstead, Md		
21. Signature of Funeral Service Licensee Steven W. Elaine				22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Acute pneumonia Due to (or as a consequence of):  b. Chronic renal failure Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 days 7 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how Injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Philip J. Ruzbarsky, M.D.				29c. License number D 33599		29d. Date signed (Month, Day, Year) 07-02-1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip J. Ruzbarsky, M.D. 125 Airport Drive Suite 34 Westminster, MD 21157									
31. Date filed (Month, Day, Year) JUL 0 2 1999			32. Registrar's Signature Benita B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22462

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Laura Elizabeth Miller</b>				2. Date of Death Month <b>July</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>6:57am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>216-01-1352</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 9, 1901</b>	
	9. Birthplace (State or Foreign Country) <b>Delaware</b>		10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1617 Exeter Road</b>		10f. Zip Code <b>21157</b>		
10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Telegraph Co.</b>		
17. Father's Name (First, Middle, Last) <b>Harry Howard Sines</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Olive Pearl Knight</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Gene Sines/Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>727 Glen Drive, Westminster MD 21157</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadow Branch Cem. 7/3/99</b>		20c. Location - City or Town, State <b>Westminster, MD</b>		
21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>91 Willis Street 21157 Myers Funeral Home Westminster, MD</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PNEUMONIA BILATERAL</b> Due to (or as a consequence of): <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>10 DAYS</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how Injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature] INTERNIST</b>				
29c. License number <b>D 52035</b>				29d. Date signed (Month, Day, Year) <b>JULY 1 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BINU CHACKO 295 Stoner Avenue, Westminster MD 21157</b>								
31. Date filed (Month, Day, Year) <b>JUL 02 1999</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

*[Handwritten signature or initials.]*

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22463

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Linda E. McDonald						2. Date of Death Month Day Year June 25 1999		3. Time of Death 0805		
	4a. Facility Name (If not institution, give street and number) Anne-Arundel Medical Center						4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne-Arundel		
Funeral Director	5. Social Security Number 222-30-8296		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) May 1, 1948		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent										
10a. State MD		10b. County Queen Anne's		10c. City, Town or Location Chester				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 303 Elliott Dr				10f. Zip Code 21619				10g. Citizen of What Country? US			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operator				16b. Kind of Business/Industry Telephone			
17. Father's Name (First, Middle, Last) Robert W. Miller						18. Mother's Name (First, Middle, Maiden Surname) Sadie Moran					
19a. Informant's Name/Relationship (Type, Print) Larry W. Miller - brother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Delaware Ave, Seaford, DE 19973					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Cramatory		20c. Location - City or Town, State Dover, DE		20d. Date 6/26/99			
21. Signature of Funeral Service Licensee John A. Cranston				22. Name and Address of Facility Cranston Funeral Home P O Box 967, Seaford, DE 19973							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Intracerebral Bleed Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 24 hours	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Robert T. Peterson MD				29c. License number 124804				29d. Date signed (Month, Day, Year) 6-25-99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert T. Peterson 600 Ridgely Ave Annapolis MD 21401											
31. Date filed (Month, Day, Year) JUN 29 1999				32. Registrar's Signature Dennis B Sparks							

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Handwritten signature and date: 10/10/10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

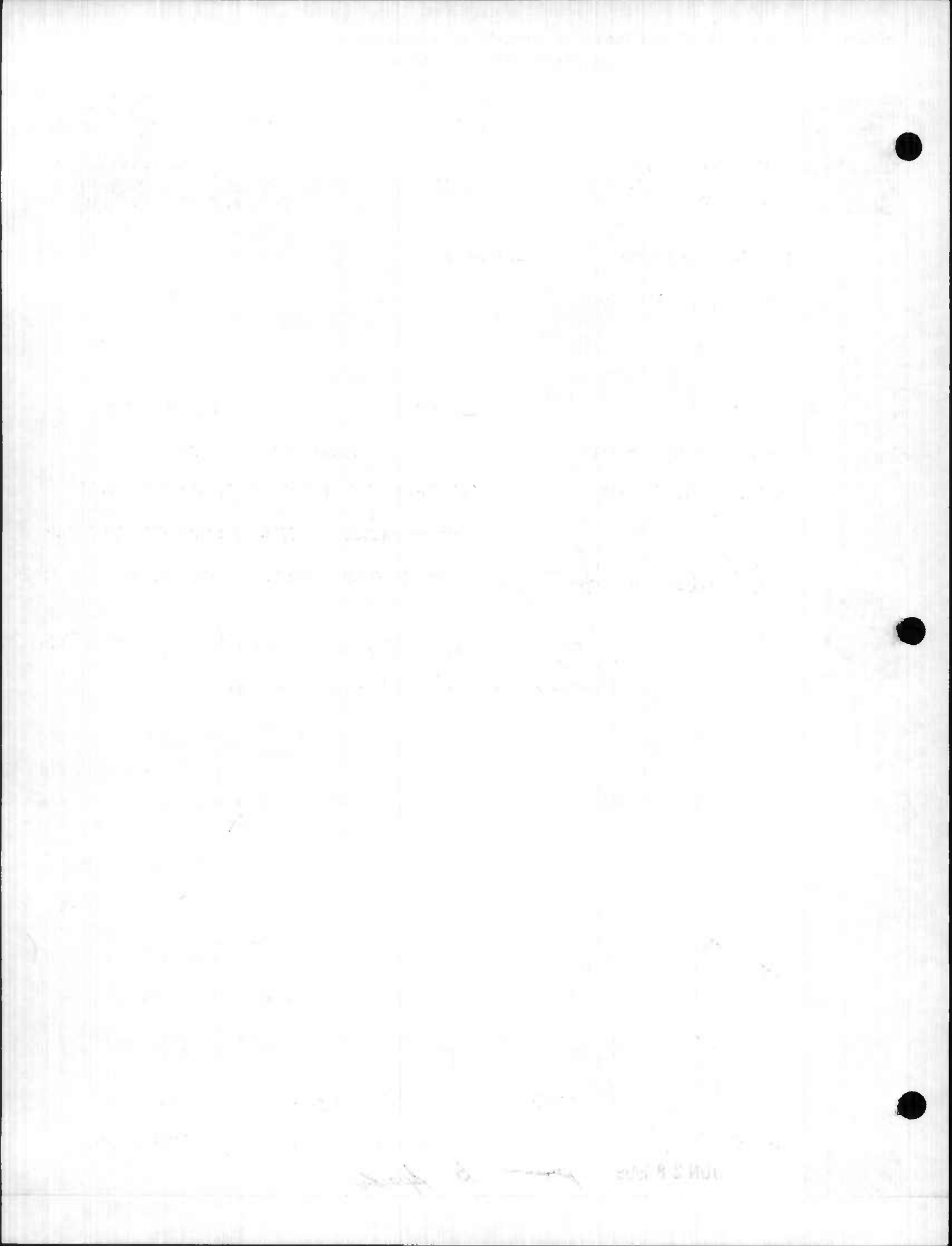
99 22464

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARTHUR LEE McCABE JR.				2. Date of Death Month: JUNE Day: 25 Year: 1999		3. Time of Death 12:05 PM	
	4a. Facility Name (If not institution, give street and number) 13342 SELBY ROAD				4b. City, Town, or Location of Death BISHOPVILLE		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 222-20-8176		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 9, 1935	
	9. Birthplace (State or Foreign Country) DELAWARE		10a. State MARYLAND		10b. County WORCESTER		10c. City, Town or Location BISHOPVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 10728 BISHOPVILLE ROAD		10f. Zip Code 21813		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER		16b. Kind of Business/Industry CONSTRUCTION			
	17. Father's Name (First, Middle, Last) ARTHUR LEE McCABE				18. Mother's Name (First, Middle, Maiden Surname) KATHERINE SAUNDERS			
	19a. Informant's Name/Relationship (Type, Print) KAY S. RUNYON/SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13342 SELBY ROAD, BISHOPVILLE, MARYLAND 21813			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY		20c. Location - City or Town, State SALISBURY, MARYLAND		20d. Date 6/26/99	
	21. Signature of Funeral Service Licensee <i>Charles W. Blazey</i>				22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Progressive Cancer metastasis</i> Due to (or as a consequence of): b. <i>Cancer of Pyiform sinus</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>[Signature]</i> MD				29c. License number D45485		29d. Date signed (Month, Day, Year) 6/25/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott A Edwards MD 100 E. Carroll St Salisbury MD 21801							
	31. Date filed (Month, Day, Year) JUN 28 1999				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22465

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RENNISON ALFRED MABY

2. Date of Death  
Month Day Year  
June 24, 1999

3. Time of Death  
1045

4a. Facility Name (If not Institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

231-52-6881

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 17, 1921

9. Birthplace (State or Foreign Country)

ENGLAND

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

FENWICK ISLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

36 MADISON AVENUE

10f. Zip Code

19944

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SALES EXECUTIVE

16b. Kind of Business/Industry

AREOSPACE

17. Father's Name (First, Middle, Last)

ALFRED MABY

18. Mother's Name (First, Middle, Maiden Surname)

ROSE YOUNG

19a. Informant's Name/Relationship (Type, Print)

JOAN M. MABY/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36 MADISON AVENUE, FENWICK ISLAND, DE. 19944

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SALISBURY CREMATORY

Date

6/25/99

20c. Location - City or Town, State

SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee

*Charles W. Sparks*

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis  
Due to (or as a consequence of):

1 week

b. Neutropenia  
Due to (or as a consequence of):

10 days

c. Colon Cancer  
Due to (or as a consequence of):

3 months

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Toxic Diarrhea

Volume Depletion

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
injury

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*James E. Markin, M.D.*

29c. License number

030692

29d. Date signed (Month, Day, Year)

June 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James E. Markin, M.D., 145 E. Carroll St., Salisbury, MD 21801

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 28 1999

32. Registrar's Signature

*James B. Sparks*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

RENNISON MABY

*Handwritten signature*

CRP 8 S HUL

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22466

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nellie Ellen Olson				2. Date of Death Month Day Year July 11 1999				3. Time of Death 1554	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney, Md.				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-20-6647		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 75		8. Date of Birth (Month, Day, Year) Sept. 28, 1923		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 224 Paula Lynn Drive				10f. Zip Code 20904		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ret. Office Manager				16b. Kind of Business/Industry Mrs. Smith's Pie Company		
17. Father's Name (First, Middle, Last) Harry Lee Barb				18. Mother's Name (First, Middle, Maiden Surname) Laura Estelle Funkhouser						
19a. Informant's Name/Relationship (Type, Print) Carrol Alden Olson, Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 Paula Lynn Drive, Silver Spring, Md. 20904						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St Paul's Luth Ch Cem		20c. Location - City or Town, State Jerome, Va.		20d. Date 7/14/99		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Dellinger Funeral Home, 157N Main St. Woodstock, Va. 22664						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Distributive Shock (Cardiogenic) 3 days b. Sepsis 7 days c. Respiratory Distress Syndrome 21 days d. Pneumonia 28 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Abdominal Aneurysm Hypertension										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) —		28b. Time of Injury — M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred —		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of Certifier 		29c. License number D51908		29d. Date signed (Month, Day, Year) July 12, 1999				
30. Name and address of person who completed cause of death (from 23a) (Type, Print) 1811 Prince Phillip Drive Suite 321 Olney Md. 20832										
31. Date filed (Month, Day, Year) JUL 16 1999		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



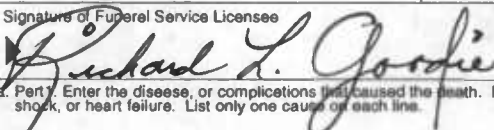
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22467

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>TRACEY S. PALMER JR</b>				2. Date of Death Month Day Year <b>JULY 4 1999</b>		3. Time of Death <b>11:30 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>Baltimore City</b>		
Funeral Director	5. Social Security Number <b>073-38-8481</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 13, 1945</b>		
	9. Birthplace (State or Foreign Country) <b>Ohio</b>		10a. State <b>PA</b>		10b. County <b>Lancaster</b>		10c. City, Town or Location <b>Lancaster</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2618 Beechwood Rd.</b>		10f. Zip Code <b>17601</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Insurance Agent</b>		16b. Kind of Business/Industry <b>State Farm Insurance</b>		17. Father's Name (First, Middle, Last) <b>T. Sloane Palmer</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Kathleen Turner</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Judy Palmer/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2618 Beechwood Rd. Lancaster, PA 17601</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lancaster Valley Mennonite Cemetery</b>		20c. Location - City or Town, State <b>7-8-99 Lancaster, PA</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. PRIMARY PULMONARY HYPERTENSION</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death <b>MONTHS</b>	
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD		29c. License number <b>RES-000</b>	
29d. Date signed (Month, Day, Year) <b>JULY 4, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TZE-MING CHEN, JHH 600 NORTH WOLFE ST., BALT., MD 21287</b>		31. Date filed (Month, Day, Year) <b>JUL 06 1999</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1972-1973

1972-1973

1972-1973

1972-1973

1972-1973

1972-1973

1972-1973

1972-1973



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 22468

1. Decedent's Name (First, Middle, Last) <b>Jennie E. Plater</b>		2. Date of Death Month <b>July</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>8:00pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Civista Medical Center</b>		4b. City, Town, or Location of Death <b>LaPlata</b>		4c. County of Death <b>Charles</b>	
5. Social Security Number <b>215-74-6321</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>March 31, 37</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Charles</b>	
10c. City, Town or Location <b>Waldorf</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>65670 Leonardtown Rd</b>		10f. Zip Code <b>20601</b>		10g. Citizen of What Country? <b>U.S.A</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	
16b. Kind of Business/Industry <b>Domestic</b>		17. Father's Name (First, Middle, Last) <b>Robert E. Plater</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Toye</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Juanita Parker/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>-Wm Wharf Rd, Box 3790 St. Leonard MD 20685</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Marys CH</b>		20c. Location - City or Town, State <b>July 6, 99 Bryantown Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Adams Funeral Home P.A. Aquasco MD 20608</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>a. Respiratory failure</b> <b>b. Renal failure</b> <b>c. Gastrointestinal Bleeding</b> <b>d. Hepatitis C</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death <b>4 days</b> <b>2 yrs</b> <b>2 days</b> <b>10 yrs</b>	
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ascites, Hypertension, Anemia</b> <b>Chronic obstructive pulmonary disease</b>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D - 08370</b>	
29d. Date signed (Month, Day, Year) <b>7/1/99</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul E. Pritchett, MD 118 LaGrange Avenue, P.O. Box 1317, LaPlata, Maryland 20646</b>					
31. Date filed (Month, Day, Year) <b>JUL 06 1999</b>		32. Registrar's Signature 			

Jennie E Plater  
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

*[Faint handwritten notes, mostly illegible due to fading.]*

*[Signature]*

*[Faint handwritten notes, mostly illegible due to fading.]*

jhm  
RUSSEL F.  
RASIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22469

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

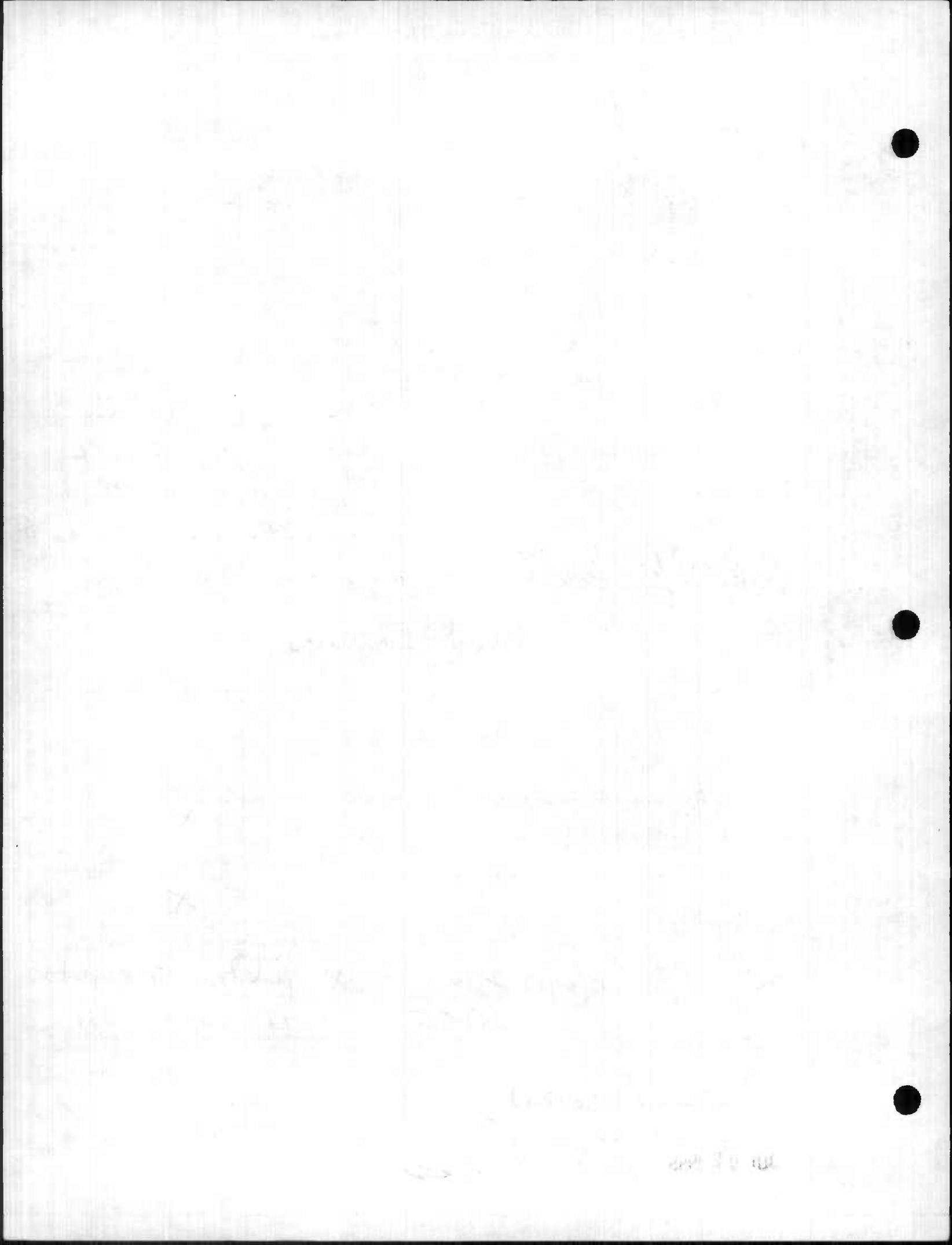
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
DirectorPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Russell F. RASIN</b>		2. Date of Death Month Day Year <b>JUNE 28, 1999</b>		3. Time of Death <b>10:05 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death
5. Social Security Number <b>154-09-9308</b>	6. Sex <b>100 M 200 F</b>	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4 30 1915</b>
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>					
10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>EASTON</b>	
10d. Inside City Limits <b>100 Yes 200 No</b>		10e. Street and Number <b>122 S. LOCUST ST.</b>		10f. Zip Code <b>21601</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <b>100 Never Married 200 Married 300 Widowed 400 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>100 Yes 200 No</b>	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>100 Yes 200 No</b>		14. Race - American Indian, Black, White, etc. <b>Specify: BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>100</b> College (1-4 or 5+) <b>0</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CAB DRIVER</b>		16b. Kind of Business/Industry <b>TAXI Co.</b>			
17. Father's Name (First, Middle, Last) <b>JAMES NORMAN RASIN Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>CLARA MAC RUSSELL</b>		
19a. Informant's Name/Relationship (Type, Print) <b>BARBARA DADE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 E 23rd ST, Wilm, De 19802</b>		
20a. Method of Disposition <b>100 Burial 200 Cremation 300 Removal from State 400 Donation 500 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Haven Memorial Cemetery</b>		20c. Location - City or Town, State <b>7/2/99 Chester Township PA</b>	
21. Signature of Funeral Service Licensee <b>Chen P. Congo</b>		22. Name and Address of Facility <b>Congo Funeral Home 201 N. GRAY Ave. Wilm. De 19805</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Head Injuries</b>					
23b. Did tobacco use contribute to the cause of death? <b>100 Yes 200 No 300 Probably 400 Unknown</b>					
24a. Was an autopsy performed? <b>100 Yes 200 No</b>					
24b. Were autopsy findings available prior to completion of cause of death? <b>100 Yes 200 No</b>					
25. Was case referred to medical examiner? <b>100 Yes 200 No</b>					
26. Place of Death (Check only one) Hospital: <b>100 Inpatient 200 ER/Outpatient 300 DOA</b> Other: <b>400 Nursing Home 500 Residence 600 Other (Specify)</b>					
27. Manner of Death <b>100 Natural 200 Accident 300 Suicide 400 Homicide 500 Pending Investigation 600 Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>6/27/99</b>		28b. Time of Injury <b>2330 M</b>	
28c. Injury at Work? <b>100 Yes 200 No</b>		28d. Describe how injury occurred <b>pedestrian struck by auto</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>Rte. 50 / Ave. 331</b>	
29a. Certifier (Check only one) <b>100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 200 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>					
29b. Signature and title of certifier <b>Barbara Congo</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JUNE 29, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. A. L. Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date of Death (Month, Day, Year) <b>JUL 02 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND 6/28/99 CMH AACO HEALTH DEPT State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

99 22470

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>TILGHMAN D. RAWLINGS, JR.</b>		2. Date of Death Month <b>June</b> Day <b>24</b> Year <b>1999</b>		3. Time of Death <b>0711</b>
	4a. Facility Name (If not institution, give street and number) <b>6873 Old Solomons Isl Rd</b>		4b. City, Town, or Location of Death <b>Friendship</b>		4c. County of Death <b>AA</b>
Funeral Director	5. Social Security Number <b>212-28-6411</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>June 24, 1930</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Friendship</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>P.O. Box 70</b>			10f. Zip Code <b>20758</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waterman</b>		16b. Kind of Business/Industry <b>Marine Carpenter</b>
17. Father's Name (First, Middle, Last) <b>Tilghman D. Rawlings, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Rupp</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Sherry L. Crow (niece)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 70, Friendship, Maryland 20758</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Bluff Cemetery</b>		20c. Location - City or Town, State <b>6/28/99 Annapolis, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Beverly M. Bader</b>		22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</b>			
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Cardiac Insufficiency</b> Due to (or as a consequence of): <b>b. Arteriosclerotic Heart Disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>William P. Jones, MD Deputy</b>		29c. License number <b>D 06054</b>		29d. Date signed (Month, Day, Year) <b>6/24/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William P. Jones, MD 695 America 21035</b>					
31. Date filed (Month, Day, Year) <b>JUN 28 1999</b>		32. Registrar's Signature <b>P. Sparks</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22471

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRIS J. RAINEY</b>				2. Date of Death Month Day Year <b>JULY 03, 1999</b>		3. Time of Death <b>1:17 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST. MARYS HOSPITAL</b>				4b. City, Town, or Location of Death <b>LEONARDTOWN</b>		4c. County of Death <b>ST. MARYS</b>	
Funeral Director	5. Social Security Number <b>579-10-3188</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>October 16, 1917</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>La Plata</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>7230 Rainey Place</b>				10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1946-1951</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>			16b. Kind of Business/Industry <b>Federal Govt.</b>	
17. Father's Name (First, Middle, Last) <b>James Andrew Rainey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Beatrice Gross Watson</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Nannie Rainey</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7230 Rainey Place La Plata, MD 20646</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans</b>		Date <b>7/9/99</b>		20c. Location - City or Town, State <b>Cheltenham, MD</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>MOORE</b>				22. Name and Address of Facility <b>AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA, MD 20646</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cardio respiratory Arrest</b> Due to (or as a consequence of):  b. <b>Suspected Sepsis</b> Due to (or as a consequence of):  c. <b>Pneumonia</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <div style="position: absolute; left: 300px; top: 550px; font-size: 40px;">}</div>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>DIABETES; COPD; DEMENTIA; S/P CVA</b> <b>SEIZURE DISORDER</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>
29c. License number <b>D39605</b>				29d. Date signed (Month, Day, Year) <b>JULY 3, 1999</b>				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>R. WESLEY PAGE MD ST. MARYS HOSPITAL LEONARDTOWN, MD 20650</b>								
31. Date filed (Month, Day, Year) <b>JUL 06 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

RAINEY, HARRIS J.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22472

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Charles Herschel Reese</b>				2. Date of Death Month <b>June</b> Day <b>28</b> Year <b>1999</b>		3. Time of Death <b>11:59 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>217-12-2896</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 27, 1914</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Walkersville</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
10e. Street and Number <b>10303 Old Annapolis Rd.</b>				10f. Zip Code <b>21793</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1941-45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>7</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>engineer</b>		16b. Kind of Business/Industry <b>oil company</b>	
17. Father's Name (First, Middle, Last) <b>Harvey E. Reese</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gula Barnes</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Joan Albaugh/ niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13405 Rabbit Run Terrace Union Bridge, MD 21791</b>			
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Linganore Cemetery</b>		Date <b>7/1/99</b>		20c. Location - City or Town, State <b>Unionville, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hartzler Funeral Home</b> <b>11802 Liberty Rd. Libertytown, MD 21762</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Kidney Failure</b> Due to (or as a consequence of): <b>b. Bladder Cancer</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Chronic Obstructive Pulmonary Disease</b>						Approximate Interval Between Onset and Death <b>1 year</b> <b>years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown	
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No					
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and Title of certifier 				29c. License number <b>D16428</b>		29d. Date signed (Month, Day, Year) <b>6/29/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Casper E. Cline III 300 W. 9th St. Frederick, MD 21701</b>							
31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22473

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LELA ELIZABETH STEWART</b>				2. Date of Death Month Day Year <b>July 4 1999</b>		3. Time of Death <b>21:55</b>		
	4a. Facility Name (If not institution, give street and number) <b>Laurelwood Nursing Center</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>241-26-8218</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 15, 1916</b>		
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>100 Laurel Drive</b>		10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Her Own Home</b>		17. Father's Name (First, Middle, Last) <b>Samuel Presnell</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mattie Presley</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Gail C. Ess / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8 Mackey Court, Landenberg, PA 19350</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>North East Methodist Cem.</b>		20c. Location - City or Town, State <b>North East, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Crouch Funeral Home</b> <b>127 South Main Street, North East, MD 21901</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>CANCER, LUNGS</b> Due to (or as a consequence of): b. <b>DIABETES MELLITUS</b> Due to (or as a consequence of): c. <b>ARTERIOSCLEROTIC CIRCULATORY AND BLOOD VESSEL DISEASES</b> Due to (or as a consequence of): d.  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>3 MONTHS</b> <b>10 YEARS</b> <b>10 YEARS</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 07463</b>		29d. Date signed (Month, Day, Year) <b>7-6-99</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Rolando Najera, 111 W. High Street, Elkton, Maryland 21921</b>		31. Date filed (Month, Day, Year) <b>JUL 06 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]*

*[Faint text at the bottom of the page, possibly a signature or date.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22474

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian Helen Spence

2. Date of Death

July 2 1999

3. Time of Death

2340

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

221-20-5810

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 7, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

320 Friendship Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In her own home

17. Father's Name (First, Middle, Last)

Willard Wright

18. Mother's Name (First, Middle, Maiden Surname)

Adele Walstrum

19a. Informant's Name/Relationship (Type, Print)

Susan A. Schafer/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

316 Nottingham Road, Trailer B, Elkton, Maryland 21921

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

R.A. Ferris and Company

Date

7/6/99

20c. Location - City or Town, State

West Chester,  
Pennsylvania

21. Signature of Funeral Service Licensee

Donald S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 West Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. acute gangrene of Intestine (prob. mesenteric Thrombosis) 6 hrs  
Due to (or as a consequence of):b. COPD 6 yrs  
Due to (or as a consequence of):c. acute myocardial infarction 2 yrs  
Due to (or as a consequence of):

d. Emphysema

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD

ASVD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jui Chih Han MD

29c. License number

D04623

29d. Date signed (Month, Day, Year)

7/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUI CHIH HSU MD 223 West main st. Elkton Md 21921

31. Date filed (Month, Day, Year)

JUL 06 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

State  
Registrar

1. Introduction

2. Objectives

3. Methodology

4. Results

5. Discussion

6. Conclusion

7. References

8. Appendix

9. Bibliography

10. Acknowledgements

11. Contact Information

12. Appendix

13. Appendix

14. Appendix

15. Appendix

16. Appendix

17. Appendix

18. Appendix

19. Appendix

20. Appendix

21. Appendix

22. Appendix

23. Appendix

24. Appendix

25. Appendix

26. Appendix

27. Appendix

28. Appendix

29. Appendix

30. Appendix

31. Appendix



Justin Christopher Slack

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend ITEMS: #23 PART I, 27 PER MEO

Certificate of Death

Reg. No.

99 22475

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JUSTIN CHRISTOPHER SLACK</b>				2. Date of Death Month Day Year <b>June 30, 1999</b>		3. Time of Death <b>8:13 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>212-27-4310</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>14</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APRIL 30, 1985</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>CHARLES</b>	10c. City, Town or Location <b>WALDORF</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3514 FOX RIDGE ROAD</b>			10f. Zip Code <b>20601</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STUDENT</b>		16b. Kind of Business/Industry <b>THOMAS STONE HIGH SCHOOL</b>			
	17. Father's Name (First, Middle, Last) <b>DAVID RUSSELL HAMILTON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SANDRA MARIE SLACK</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>DAVID SLACK-UNCLE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS #10</b>				
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TRINITY MEMORIAL GARDEN</b>			20c. Location - City or Town, State <b>7-6-99 WALDORF, MARYLAND</b>		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARDIAC ARRHYTHMIA IN ASSOCIATION WITH a. HEMORRHAGE &amp; NECROSIS OF CARDIAC CONDUCTION SYSTEM</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>July 01, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>JUL 06 1999</b>		32. Registrar's Signature 						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22476

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grace Louise Saltzgaver

2. Date of Death

Month Day Year  
6 30 99

3. Time of Death

10:53A

4a. Facility Name (If not institution, give street and number)

101 Thomas St.

4b. City, Town, or Location of Death

Union Bridge

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

213-16-0224

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 27, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Union Bridge

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

101 Thomas St.

10f. Zip Code

21791

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

clerk

16b. Kind of Business/Industry

railways

17. Father's Name (First, Middle, Last)

George B. Eyler

18. Mother's Name (First, Middle, Maiden Surname)

Gertie I. Sayler

19a. Informant's Name/Relationship (Type, Print)

Gene Saltzgaver - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Tokyo Apt. 103 Sowazu, 6-7 Daikyochu, Shinjuku-ku 160-0015

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Pipe Creek Cemetery

Date

7/3/99

20c. Location - City or Town, State

near Linwood, MD

21. Signature of Funeral Service Licensee

Catherine O. Hartzler

22. Name and Address of Facility

Hartzler Funeral Home

6 E. Broadway, Union Bridge, MD 21791

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Carcinoma, breast - mets to bone

Due to (or as a consequence of):

Approximate interval between Onset and Death

11/1990

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. H. Caricofe MD

29c. License number

D0906

29d. Date signed (Month, Day, Year)

6/30/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. H. Caricofe MD, P.O. Box 1110 Union Bridge MD 21791

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22477

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH A WORMWOOD</b>				2. Date of Death Month <b>80</b> Day <b>28</b> Year <b>99</b>		3. Time of Death <b>0150</b>
	4a. Facility Name (If not institution, give street and number) <b>ANNAPOLIS NSG &amp; Rehab CTR</b>				4b. City, Town, or Location of Death <b>ANAPOLIS</b>		4c. County of Death <b>AN</b>
Funeral Director	5. Social Security Number <b>217-26-9721</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 20, 1903</b>	9. Birthplace (State or Foreign Country) <b>Maine</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1206 President Street</b>			10f. Zip Code <b>21403</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1919-44</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrician</b>		16b. Kind of Business/Industry <b>Contractor</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Daniel Wormwood</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Edna R. Hambruch- Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1206 President St. Annapolis, Md 21403</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Md. State Veterans Cam.</b>		Date <b>6-30-99</b>	20c. Location - City or Town, State <b>Crownsville, Md.</b>	
	21. Signature of Funeral Service Licensee <b>C. Brian Powell</b>				22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. aspiration pneumonia</b> Due to (or as a consequence of): <b>b. Dermatitis</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>72h</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypothyroidism</b> <b>CRF secondary to HTN</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Michael J. Pentam</b>				29c. License number <b>021438</b>		29d. Date signed (Month, Day, Year) <b>June 28 99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL J. PENTAM BOOKING AGENCY 120 ANAPOLIS MD 21401</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>			32. Registrar's Signature <b>G. Sparks</b>			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Sylvia B. Walters 2. Date of Death Month Day Year June 29, 1999 3. Time of Death 5:30 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 7303 Charleston Avenue 4b. City, Town, or Location of Death North Beach 4c. County of Death Anne Arundel

5. Social Security Number 174-28-4620 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birthday) 62 Yrs. 8. Date of Birth (Month, Day, Year) Sept. 7, 1936 9. Birthplace (State or Foreign Country) Pennsylvania

Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location North Beach 10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 7303 Charleston Avenue 10f. Zip Code 20714 10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant in State Aid for Special Education 16b. Kind of Business/Industry P.G. Co. Public Schools

17. Father's Name (First, Middle, Last) Robert M. Brewen 18. Mother's Name (First, Middle, Maiden Surname) Hanna Laubach

19a. Informant's Name/Relationship (Type, Print) Gerald E. Walters/ Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7303 Charleston Ave. North Beach, MD 20714

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Windgap Cemetery 20c. Location - City or Town, State Windgap, Pennsylvania

21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory arrest Due to (or as a consequence of): b. Progressive Breast Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles R. Boice, M.D. 2001 Medical Pkwy. Annapolis, Maryland 21401

31. Date filed (Month, Day, Year) JUL 01 1999 32. Registrar's Signature

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22479

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Karl Christian Stickel</b>						2. Date of Death Month Day Year <b>June 28, 1999</b>		3. Time of Death <b>7:21 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>2818 Snydersburg Road</b>						4b. City, Town, or Location of Death <b>Hampstead</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>215-24-5959</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 8, 1928</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Hampstead</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2818 Snydersburg Road</b>				10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business/Industry <b>Teamsters</b>			
17. Father's Name (First, Middle, Last) <b>Bernard Stickel</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Helda Marie Fisher</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Virginia Stickel, wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2818 Snydersburg Rd, Hampstead, MD 21074</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Snydersburg Cemetery</b>		20c. Date <b>7/2</b>		20d. Location - City or Town, State <b>Hampstead, MD</b>		
21. Signature of Funeral Service Licensee <b>Steven W. Elme</b>				22. Name and Address of Facility <b>Eline Funeral Home 934 South Main St, Hampstead, MD 21074</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Lung Cancer</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how Injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Philip Kont</b>						29c. License number <b>024321</b>		29d. Date signed (Month, Day, Year) <b>6/29/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Kont 2059 Baltimore Blvd, Finksburg, Md 21048</b>										
31. Date filed (Month, Day, Year) <b>JUL 01 1999</b>				32. Registrar's Signature <b>B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CONFIDENTIAL

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-22480

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mae L. Trussell

2. Date of Death

June 30, 1999

3. Time of Death

13:30

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Center Rising Sun

4b. City, Town, or Location of Death

4c. County of Death

Cecil

5. Social Security Number

061-09-6841

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

7/14/17

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1881 Telegraph Road

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

clerical

16b. Kind of Business/Industry

retail

17. Father's Name (First, Middle, Last)

Harry McCumber

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Struewe

19a. Informant's Name/Relationship (Type, Print)

Phyllis Keith / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Linder Circle Lincoln University, PA 19352

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodbown Cemetery

Date

7/6/99

20c. Location - City or Town, State

Raytown, MO

21. Signature of Funeral Service Licensee

Kevin S. Collins

22. Name and Address of Facility

Collins Funeral Home Oxford PA 19363

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Weeks

b.

Gangrene left leg

Due to (or as a consequence of):

Weeks

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Atrial fibrillation, CVA

Aortic insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H Farkas, MD

29c. License number

D 15314

29d. Date signed (Month, Day, Year)

July 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H Farkas, MD VNA/CH 111 High St, suite 307, Elkton, MD

31. Date filed (Month, Day, Year)

JUL 02 1999

32. Registrar's Signature

B. Spores

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



John Woodrow

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Bullock Woodrow				2. Date of Death Month Day Year June 28, 1999		3. Time of Death 0216	
	4a. Facility Name (If not institution, give street and number) Union Hospital				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 217-12-0324		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	8. Date of Birth (Month, Day, Year) February 4, 1923		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 586 Leeds Road				10f. Zip Code 21921		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Agriculture		
17. Father's Name (First, Middle, Last) John W. Woodrow				18. Mother's Name (First, Middle, Maiden Surname) Hannah Bullock				
19a. Informant's Name/Relationship (Type, Print) Patricia A. Lusby/ Great Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 216, Pomeroy, Pennsylvania 19367				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Leeds Cemetery		Date 7/2/99		20c. Location - City or Town, State Leeds, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Urosepsis Due to (or as a consequence of): b. Bone CA Due to (or as a consequence of): c. Renal failure Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 2 days 6 mos. 2 days								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D44716		29d. Date signed (Month, Day, Year) June 28, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jose Ma M.D. 111 West High Street, Elkton, Maryland 21921								
31. Date filed (Month, Day, Year) JUN 30 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

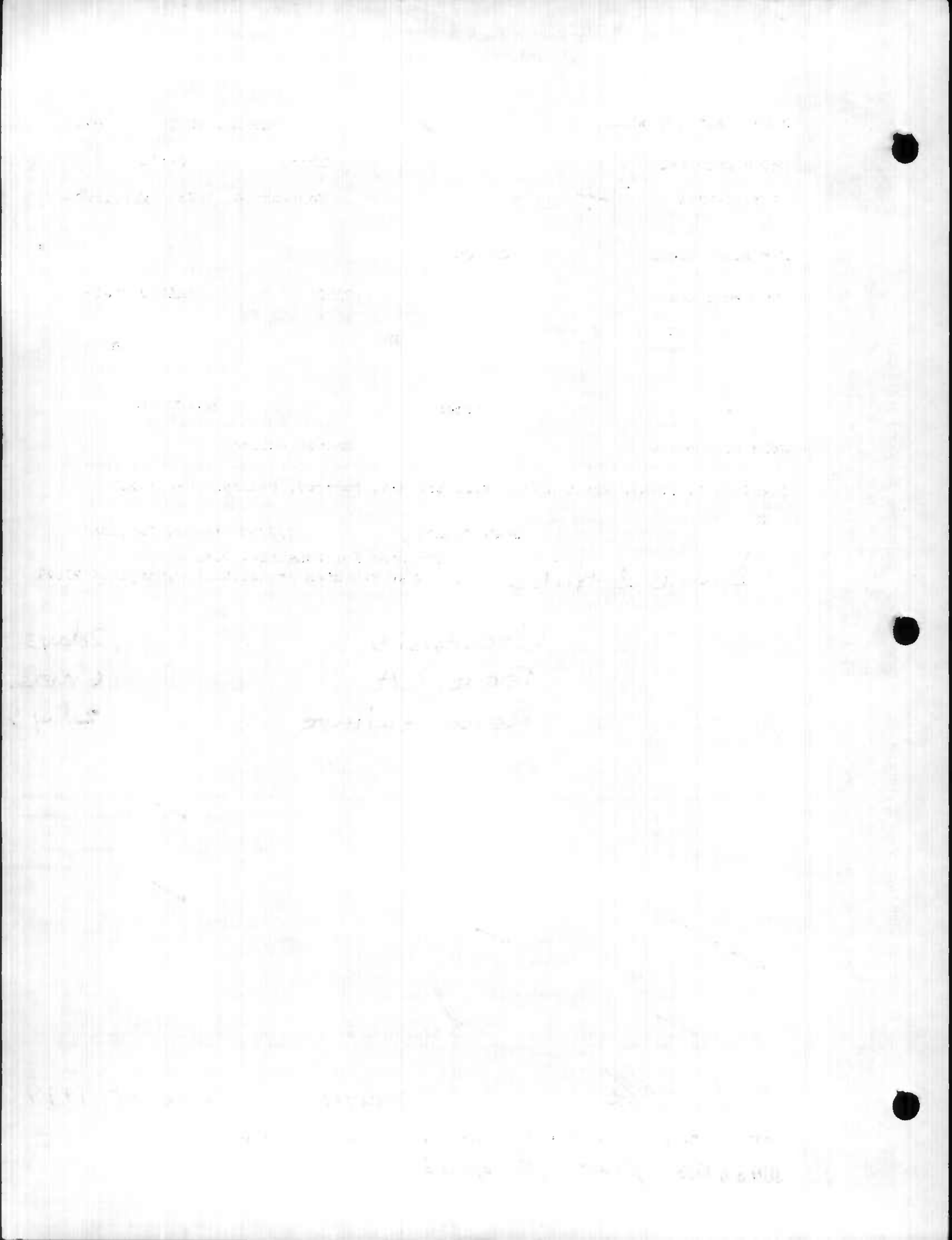
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22482

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Mary Wanex					2. Date of Death Month Day Year June 23 1999			3. Time of Death 4:15 PM	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice					4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-38-4874		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) Oct. 2, 1910		9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent										
10a. State MD		10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3901 Dulaney Valley Road				10f. Zip Code 21204			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own home		
17. Father's Name (First, Middle, Last) Frank Ruzicka					18. Mother's Name (First, Middle, Maiden Sumama) Mary Chervat					
19a. Informant's Name/Relationship (Type, Print) Marge Evans / daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Cedar Heights Rd. Stamford, CT. 06905					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery			Data 6-26-99		20c. Location - City or Town, State Annapolis, MD.		
21. Signature of Funeral Service Licensee C. Brian Powell					22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Stage Dementia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier MD					29c. License number D43725			29d. Date signed (Month, Day, Year) 6/25/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 821 N. Eutan St Suit 816 Baltimore Maryland.										
31. Date filed (Month, Day, Year) JUN 28 1999			32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



ADH  
JAMES M. WOLFF, JR.  
99-3818-013

Amended Item 12 per F.D. 7/7/99, Carroll County-jab  
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23, 27, 28A-F PER MEO G773 7-19-99 WR.

Certificate of Death

Reg. No.

99 22483

Baltimore, Maryland 21215-0020  
To Be Completed by Funeral Director

Physician / Medical Examiner  
To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last) <b>James M. Wolff, Jr.</b>		2. Date of Death Month Day Year <b>JULY 3, 1999</b>		3. Time of Death <b>1230 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>6604 SYKESVILLE ROAD</b>		4b. City, Town, or Location of Death <b>ELDERSBURG</b>		4c. County of Death <b>CARROLL</b>	
5. Social Security Number <b>212 50 6828</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>53</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>April 24, 1946</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>			
10a. State <b>Md.</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1514 Springlake Way</b>		10f. Zip Code <b>21784</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Splicer</b>		16b. Kind of Business/Industry <b>Bell Atlantic</b>		17. Father's Name (First, Middle, Last) <b>James M. Wolff, Sr.</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Dolores Franz</b>		19a. Informant's Name/Relationship (Type, Print) <b>Donna J. Wolff (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1514 Springlake Way Sykesville, Md. 21784</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Mem. Park</b>		20c. Location - City or Town, State <b>7/7/99 Sykesville, MD</b>	
21. Signature of Funeral Service Licensee <b>Haight</b>		22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O.Box 195 Sykesville, Md. 21784</b>		23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>DROWNING COMPLICATING ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>		27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year) <b>7-3-99</b>		28b. Time of Injury <b>8:00</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred <b>SUBJECT FELL INTO A WELL.</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>PLANT NURSERY</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6604 SYKESVILLE ROAD CARROLL COUNTY MARYLAND</b>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Stephen S. Radentz, MD</b>		29c. License number <b>OCME</b>	
29d. Data signed (Month, Day, Year) <b>JULY 4, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>JUL 07 1999</b>	
32. Registrar's Signature <b>B. Sparks</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22484

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles H Wilkins

2. Date of Death

June 30, 1999

3. Time of Death

0330

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

215 16 3520

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-4-22

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Md

10b. County

Wicomico

10c. City, Town or Location

Pittsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7534 Gumboro Rd

10f. Zip Code

21850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

OWN FARM

17. Father's Name (First, Middle, Last)

GEORGE

EMORY

WILKINS

18. Mother's Name (First, Middle, Maiden Surname)

MARY

GRIFFIN

19a. Informant's Name/Relationship (Type, Print)

GAIL ANN MOORE - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7550 GUMBORO RD. PITTSVILLE, MD 21850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PITTSVILLE CEMETERY

Date

7/3/99

20c. Location - City or Town, State

PITTSVILLE, MD

21. Signature of Funeral Service Licensee

B. Keet P. Phyllis CFSP

22. Name and Address of Facility

705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Asystole

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

d. Chronic Nicotine dependence, obesity

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

bipolar disorder, manic

ethanol abuse

mild Azotemia + edema

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Fred A. Dittmer, MD

29c. License number

D0029536

29d. Date signed (Month, Day, Year)

6/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fred A. Dittmer 1323 Mt. Hermon Rd Suite 1B Salisbury, Md 21804

31. Date filed (Month, Day, Year)

JUL 01 1999

32. Registrar's Signature

B. Keet P. Phyllis

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance and that it has not been completely solved. The author then proceeds to a detailed analysis of the problem, showing that it is a special case of a more general problem. The author then discusses the various methods that have been used to solve the problem, and shows that the method proposed in this paper is the most efficient.

2. The second part of the paper is devoted to a detailed analysis of the problem. It is shown that the problem is a special case of a more general problem. The author then discusses the various methods that have been used to solve the problem, and shows that the method proposed in this paper is the most efficient.

JUL 1 1964  
 J. R. ...  
 ...  
 ...



WRC  
99-4060-510  
RICARDO LEON  
ALLEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G775 8-6-99 WR., **Certificate of Death**

Reg. No. **99 22485**

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RICARDO LEON ALLEN</b>				2. Date of Death Month <b>JULY</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>2:45 PM.</b>		
	4a. Facility Name (If not institution, give street and number) <b>3221 LEEDS AVE.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>214-64-0888</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>45</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-15-53</b>		
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>BALTIMORE</b>						
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE, MD</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>3221 LEEDS AVE</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Date:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) <b>DANIEL ALLEN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>DOROTHY SWANN</b>					
19a. Informant's Name/Relationship (Type, Print) <b>DANIEL ALLEN, BROTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5316 PEERLESS AVE, BALTIMORE, MD 21207</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PK</b>		20c. Location - City or Town, State <b>7-17-99 ARBUTUS MD</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO., MD 21207</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>SEIZURE DISORDER</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 							
		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HARRYDA R. KOBAN 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>JUL 19 1999</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22486

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ERMA

ARMSTRONG

2. Date of Death

Month

Day

Year

JULY

18

1999

3. Time of Death

7:20 A

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-20-3401

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

10-19-09

9. Birthplace (State or Foreign Country)

BLACK

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4109 BOARMAN AVE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

POSTAL CLERK

16b. Kind of Business/Industry

U.S. POSTAL SVR.

17. Father's Name (First, Middle, Last)

WILLIAMS GROOMS

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA HARRIS

19a. Informant's Name/Relationship (Type, Print)

LAWRENCE ARMSTRONG, HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4109 BOARMAN AVE, BALTO. MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ARBUTUS MEMORIAL PK

Date

7-23-99 BALTO. MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HOWELL FUNERAL HOME

4600 LIBERTY HGHTS AVE, BALTO. MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

CONGESTIVE HEART FAILURE

7 DAYS

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

7 DAYS

Due to (or as a consequence of):

c. ARTERIOSCLEROTIC HEART DISEASE

UNKNOWN

Due to (or as a consequence of):

d. ACUTE RENAL FAILURE

4 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES MELLITUS

OBESITY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

D. 23300

29d. Date signed (Month, Day, Year)

JULY 18 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDHIR. D. PATEL

LIBERTY MEDICAL CENTER  
2600 LIBERTY HIGHTS AVE. BALTO MD 21215

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
505.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22487

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TROY ALEXANDER AYERS JR				2. Date of Death Month Day Year JULY 10 1999		3. Time of Death 1903
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death
Funeral Director	5. Social Security Number Unknown	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	8. Date of Birth (Month, Day, Year) 7-6-99	9. Birthplace (State or Foreign Country) USA		
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Wicomico	10c. City, Town or Location Salisbury, Maryland		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 5304 Eastwood Circle		10f. Zip Code 11804		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) Troy A. Ayers			18. Mother's Name (First, Middle, Maiden Surname) Lisa Mays			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lisa Mays - mother			19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 5304 Eastwood Circle - Salisbury, Md. 11804			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Disposal		20b. Place of Disposition (Name of cemetery, crematory or other place) Johns Hopkins Hospital		20c. Location - City or Town, State Baltimore, Md.		
	21. Signature of Funeral Service Licensee Debrah Evans			22. Name and Address of Facility SHH-600 N. Wolfe St - 21287			
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY INTERSTITIAL EMPHYSEMA Due to (or as a consequence of): b. EXTREME PREMATURITY Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 4 days 4 days
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Electrolyte abnormalities Autonomic Instability						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Gail Addlestone MD			29c. License number RES-000		29d. Date signed (Month, Day, Year) 7/12/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gail Addlestone Johns Hopkins Hospital							
State Registrar	31. Date filed (Month, Day, Year) JUL 19 1999		32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22488

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH

2. Date of Death

BATES

JULY

16

1999

5:00 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

1548 MORELAND AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-05-1174

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

OCTOBER 21, 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1548 MORELAND AVENUE

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 10-5-1942  
6-4-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLAIMS EXAMINER

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

LEONARD

BATES

18. Mother's Name (First, Middle, Maiden Surname)

MARY E.

DOUGLASS

19a. Informant's Name/Relationship (Type, Print)

ERNESTINE W. BATES (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1548 MORELAND AVENUE, BALTIMORE, MARYLAND 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST CEMETERY

Date

7-22-99

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SUDDEN CARDIAC DEATH 2° ARRHYTHMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

YEARS

c. HYPERTENSION

Due to (or as a consequence of):

YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD.

29c. License number

MD D18882

29d. Date signed (Month, Day, Year)

7/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JENNIFER HAMILTON MD., DVA MEDICAL CENTER, 10 NORTH GREENE ST., BALTIMORE MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amenede Item#26 per Verbal MD G773 7/19/99 EW

Certificate of Death

Reg. No.

99 22489

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vera Muriel Nora Bragg

2. Date of Death

06/30/1999

3. Time of Death

3:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health Care Center

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

124 28 1830

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12/01/1907

9. Birthplace (State or Foreign Country)

London, England

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3206 Spartan Road #18

10f. Zip Code

20832

10g. Citizen of What Country?

United Kingdom

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Manager

16b. Kind of Business/Industry

Event Planning

17. Father's Name (First, Middle, Last)

Obd Woods

18. Mother's Name (First, Middle, Maiden Surname)

Sara Not Available

19a. Informant's Name/Relationship (Type, Print)

Pat Cheezum (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3206 Spartan Rd #18, Olney MD 20832

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

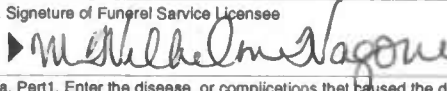
Date

7/1/99

20c. Location - City or Town, State

Alexandria VA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Advent Funeral &amp; Cremation Services

Annapolis MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Alzheimer's Dementia

Approximate Interval Between Onset and Death

Years

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recurrent Aspiration; septicemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D08944

29d. Date signed (Month, Day, Year)

6/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Shargel, MD 3720 Farragut Ave, Kensington MD 20895

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22490

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas J. Boyle

2. Date of Death

Month Day Year  
July 15, 1999

3. Time of Death

5:45AM

4a. Facility Name (If not institution, give street and number)

4216 LaSalle Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

173-16-7162

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Sept. 19, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1610 Wadsworth Way

10f. Zip Code

21239

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director of Employee Relations Brewing Company

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

George Boyle

18. Mother's Name (First, Middle, Maiden Surname)

Anne Lyden

19a. Informant's Name/Relationship (Type, Print)

Patricia M. Baker / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4216 LaSalle Avenue Baltimore, MD 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

7/19/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Timothy S. Harman

22. Name and Address of Facility

Leonard J. Ruck, Inc. Funeral Home  
5305 Harford Road Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic Stenosis, Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Daughter's Residence

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. H. Kahn

29c. License number

D28662

29d. Date signed (Month, Day, Year)

July 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian H. Kahn, M.D. 7505 Osler Drive Towson, MD 21204

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 22491

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSA LEE BOLES

2. Date of Death

July

Day

15

Year

1999

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-44-8153

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-18-1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7222 N. Alter Street

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 th

College (14 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Computer Specialist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Raymond Emory Chambers

18. Mother's Name (First, Middle, Maiden Surname)

Lila Missouri Cook

19a. Informant's Name/Relationship (Type, Print)

Kevin Boles (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Chinook Ct. Randallstown, Md. 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bushy Park Cemetery

Date

7/20/99

20c. Location - City or Town, State

Cooksville, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Caple Funeral Service

5502 Winner Ave. Balto., Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

SUDDEN CARDIAC DEATH

Due to (or as a consequence of):

b.

CARDIAC ISCHEMIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

P12561

29d. Date signed (Month, Day, Year)

July 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR ANURAG GUPTA GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22492

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice D. Brewer

2. Date of Death

Month Day Year

07

16

1999

3. Time of Death

17:45

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

208-24-8304

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

July 14, 1915

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Jessup

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7810 Clark Road A39 Holiday Mobile Est.

10f. Zip Code

20794

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Packer

16b. Kind of Business/Industry

Glass Manufacturing

17. Father's Name (First, Middle, Last)

John L. Gray

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle Hart

19a. Informant's Name/Relationship (Type, Print)

Georgia Brewer (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7810 Clark Road A39 Holiday Mobile Est. Jessup, MD 20794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wolf's Cemetery

Date

7-19-99

20c. Location - City or Town, State

Dilliner, Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Singleton Funeral Home, PA.

1 Second Ave. S.W. Glen Burnie, MD 21061

23a. Part I. Enter the condition or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory failure

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Exacerbation of Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-40521

29d. Date signed (Month, Day, Year)

July 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. OCHANEY

7845 Oakwood Road Suite 205 Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

B. Sparks

State  
RegistrarBrewer, Beatrice  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

ALEC

State of Maryland / Department of Health and Mental Hygiene

BENAVIDES AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO

**Certificate of Death**

Reg. No.

22493

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) ALEC BRANDON BENAVIDES

2. Date of Death Month JULY Day 16, Year 1999

3. Time of Death 6:17P.M.

4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL

4b. City, Town, or Location of Death ESSEX

4c. County of Death BALTIMORE

5. Social Security Number 220-45-7977

6. Sex 1 M 2 F

7. Age (In yrs. last birthday) 3 Yrs.

8. Date of Birth (Month, Day, Year) FEB. 20, 1996

9. Birthplace (State or Foreign Country) MARYLAND

10a. State MARYLAND

10b. County ANNE ARUNDEL

10c. City, Town or Location SEVERN

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 1648 SHANNON O CIRCLE

10f. Zip Code 21144

10g. Citizen of What Country? U.S.A.

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No

14. Race - American Indian, Black, White, etc. Specify: HISPANIC

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A

16b. Kind of Business/Industry N/A

17. Father's Name (First, Middle, Last) ANTHONY BEN BENAVIDES

18. Mother's Name (First, Middle, Maiden Surname) JENNIFER HENDERSON

19a. Informant's Name/Relationship (Type, Print) JENNIFER MAE HENDERSON (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1648 SHANNON O CIRCLE, SEVERN, MD. 21144

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK

20c. Location - City or Town, State 7/21/99 ELKRIDGE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. HYPERTHERMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) 7-16-99

28b. Time of Injury p 5-17-99 M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred SUBJECT TRAPPED IN CAR IN HEAT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State) 32 LETTERWOOD PLACE, BALTIMORE CO., MD

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier J. Pestaner, M.D.

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) JULY 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) JUL 19 1999

32. Registrar's Signature

ORIGINAL

and a small amount

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22494

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Raymond Blum

2. Date of Death

JULY

18

1999

7-47am

3. Time of Death

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

214 20 6406

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Dec. 18, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

207 Greenland Beach Road

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: W.W. II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

John S. Blum

18. Mother's Name (First, Middle, Maiden Surname)

Vertie M. Taylor

19a. Informant's Name/Relationship (Type, Print)

Patricia Blum / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

207 Greenland Beach Road Baltimore, Maryland 21226

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp.

Date

7/22/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE,

ATRIAL FIBRILLATION,

ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 M.D.

29c. License number

D51664

29d. Date signed (Month, Day, Year)

JULY 18 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDHIR KUMAR AGGARWAL  
NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE MD 21061State  
Registrar

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

 B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1941-1942  
1943-1944

CHIEF OF BUREAU

1945-1946  
1947-1948  
1949-1950

1951-1952  
1953-1954  
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2095-2096  
2097-2098  
2099-2100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22495

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Paul Bradley

2. Date of Death

Month  
JulyDay  
15Year  
1999

3. Time of Death

12:25 PM

4e. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

219-44-5695

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 3, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

116 W. University Pkwy.

10f. Zip Code

21218

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

parish priest

16b. Kind of Business/Industry

religion

17. Father's Name (First, Middle, Last)

John Elwood Bradley

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Lacy

19e. Informant's Name/Relationship (Type, Print)

M. Edith Bradley/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 W. University Pkwy. Baltimore, MD 21218

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

New Cathedral Cemetery

Date

7/19/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John D. Mitchell IV

22. Name and Address of Facility  
Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Rd.  
Baltimore, MD 2121223. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

HOSPICE

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Tariq

29c. License number

D4325

29d. Date signed (Month, Day, Year)

7/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State

Registrar

31. Date filed (Month, Day, Year)

JUL 19 1999

32. Registrar's Signature

Tariq

JOSEPH BRADLEY July 15, 1999 12:25 p.m.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





99-4001-510

JOHN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

7-16-99 WR

BLESSING ITEMS: #23 PART I, 27, 28A-F PER MEI G773

## Certificate of Death

Reg. No.

99 22496

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John B. Blessing</b>						2. Date of Death Month Day Year <b>JULY 9, 1999</b>		3. Time of Death <b>6:40P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>215-48-2489</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>43</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Sept. 22, 1955</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Howard</b>	
10c. City, Town or Location <b>Columbia</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>5279 Golden Sky Ct.</b>		10f. Zip Code <b>21045</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates <b>1975-77</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Alarm Technician</b>		16b. Kind of Business/Industry <b>Security</b>		17. Father's Name (First, Middle, Last) <b>John R. Blessing</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Diane Krauder</b>		19a. Informant's Name/Relationship (Type, Print) <b>John R. Blessing / father</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5279 Golden Sky Ct. Columbia, MD. 21045</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Johns Cemetery</b>		20c. Location - City or Town, State <b>Ellicott City, MD.</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. NARCOTIC INTOXICATION</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year) <b>7-9-99</b>		28b. Time of Injury <b>Found: 6:20 M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SUBJECT INGESTED NARCOTIC</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: PRIVATE DWELLING</b>		
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3501 BARCLAY STREET BALTIMORE CITY, MARYLAND</b>		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 10, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>JUL 13 1999</b>		32. Registrar's Signature 		State Registrar		DHMH 16 Rev 6/95		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 22497

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Wallace Bond</b>				2. Date of Death Month <b>July</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>11:56 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>217-07-4295</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>03-21-12</b>		
	9. Birthplace (State or Foreign Country) <b>NC</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3231 Ramona Avenue</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Longshoreman</b>		16b. Kind of Business/Industry <b>Steamship Trade</b>					
17. Father's Name (First, Middle, Last) <b>Thomas J. Bond</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Parker</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Pearl A. Chase</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3231 Ramona Avenue Baltimore, Maryland 21213</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk. Cem.</b>		20c. Location - City or Town, State <b>07-19-99 Arbutus, MD</b>					
21. Signature of Funeral Service Licensee <i>Joseph R. Walters Jr.</i>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b> Due to (or as a consequence of): <b>Decubitus Ulcers</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Diabetes Mellitus</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>1 hour</b> <b>1 day</b> <b>1 year</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Bedridden for twelve years</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.		29b. Signature and title of certifier <i>Edward Seidel</i>		29c. License number <b>P38956</b>		29d. Date signed (Month, Day, Year) <b>July 13, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Edward Seidel, 5601 Loch Raven Blvd, Baltimore, MD 21239</b>		31. Date filed (Month, Day, Year) <b>JUL 17 1999</b>		32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22498

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HOWARD BEATTY</b>				2. Date of Death Month Day Year <b>July 10 1999</b>		3. Time of Death <b>23:26</b>		
	4a. Facility Name (If not institution, give street and number) <b>Univ. of Maryland Medical System</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219-30-2696</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7/25/1935</b>		
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		
10c. City, Town or Location <b>Middle River</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>11 Tearose Drive</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Shipping Clerk</b>		16b. Kind of Business/Industry <b>State of Maryland</b>		17. Father's Name (First, Middle, Last) <b>Hamilton Diston Beatty</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Marie Wilson</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Lorraine F. Beatty</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 Tearose Drive Baltimore, MD. 21220</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. Location - City or Town, State <b>7/15/99 Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <i>Martin J. Dippel</i>		22. Name and Address of Facility <b>Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD 21206</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiac Arrest - Myocardial Infarction</b>		Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of): <b>PREVIOUS HEART ATTACK</b>		Due to (or as a consequence of): <b>HYPERTENSION, HEART FAILURE</b>		Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>K. Butler</i>		29c. License number <b>H46145</b>		29d. Date signed (Month, Day, Year) <b>7/11/1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KEN BUTLER 22 S. Greene St. Baltimore, MD 21201</b>		31. Date filed (Month, Day, Year) <b>JUL 17 1999</b>		32. Registrar's Signature <i>Denise A. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 22499

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NELLIE BRICE</b>				2. Date of Death Month <b>JULY</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>12:10 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>218-28-7571</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 26. 1919</b>		
	9. Birthplace (State or Foreign Country) <b>ENGLAND</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PARKVILLE</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8825 AVONDALE RD.</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		College (1-4or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LOADER</b>		16b. Kind of Business/Industry <b>U.S. GOVERNMENT.</b>			
17. Father's Name (First, Middle, Last) <b>EZRA RILEY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY ANN LAMB</b>					
19a. Informant's Name/Relationship (Type, Print) <b>GEORGINA M. HENNINGER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8825 A. AVONDALE RD. BALTO. MD 21234</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount CREMATORY</b>		Date <b>7/15/99</b>		20c. Location - City or Town, State <b>BALTO. MD.</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>HARTLEY MILLER Funeral Home CHFD.</b> <b>7527 HARFORD RD. BALTO. MD 21234</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>Acute Coronary Syndrome</b> Due to (or as a consequence of): <b>Severe Coronary Artery Disease</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>multiple myeloma</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number <b>D 12561</b>		29d. Date signed (Month, Day, Year) <b>JULY 13, 1999</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR ANURAG GUPTA, GOOD SAMARITAN HOSPITAL</b>						<b>5601 LOCK RAVEN BLVD. BALTO. MD 21231</b>			
31. Date filed (Month, Day, Year) <b>JUL 19 1999</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene 99 22500

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lonnie Bass</b>				2. Date of Death Month Day Year <b>June 27, 1999</b>		3. Time of Death <b>5:44 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>224-30-2877</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 19, 1927</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Bladenburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>64th Place</b>				10f. Zip Code <b>20710</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4or 5+) <b>unknown</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Tire man</b>		16b. Kind of Business/Industry <b>Automotive</b>			
17. Father's Name (First, Middle, Last) <b>unknown</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dora Williams/sister in law</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>407 11th Street, N.E., Washington, D.C. 20002</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>in state</b>		Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>					22. Name and Address of Facility <b>State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)								a. <b>Cardiac Arrhythmia</b> Due to (or as a consequence of):	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								b. <b>Myocardial Infarction</b> Due to (or as a consequence of):	1 hour
c. <b>Atherosclerosis</b> Due to (or as a consequence of):								years	
d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multiple Decubiti Wounds</b> <b>Sepsis</b> <b>Pneumonia</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>Rashid Baghai-naini, M.D.</b>							
29c. License number <b>D39372</b>		29d. Date signed (Month, Day, Year) <b>June 28, 1999</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rashid Baghai-naini, M.D. 344 University Blvd. West, #324 Silver Spring, MD 20901</b>									
31. Date filed (Month, Day, Year) <b>JUL 19 1999</b>		32. Registrar's Signature <b>B. Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

